POLICY

Revision Date: **July 2012**

AccessWV
P.O. Box 50540
Charleston, WV 25305-0540

Section 1: AccessWV

This Policy is your contract as a member of AccessWV. It describes the benefits available to you and provides instructions on how to use these benefits. It also tells you where to write or call when you have questions or concerns. Please keep it close at hand and refer to it often as you have questions about your AccessWV benefits. If you have a question about your benefits or a specific claim, the fastest way to obtain information is to contact the appropriate organization directly.

AccessWV's coverage Plans include benefits for hospital, surgical, prescription drug, and other medical expenses. Monthly premiums for AccessWV are based on the age and gender of the applicant, the geographic area where the applicant resides, the kind of coverage (individual or family coverage), and the deductible amounts and out-of-pocket maximums for medical and prescription drug benefits.

To determine the deductible amounts and out-of-pocket maximums for your coverage Plan, see the Summary of Benefits insert to this Policy.

FREE LOOK

You have the right to return this Policy. Examine it carefully. If you are not satisfied with this Policy, you may return it and ask us to cancel it. Your request must be in writing and must be made within 10 days from the date you receive this Policy. We will then refund to you any amount you paid for this Policy. If you return it in this manner, you will receive no benefits under this Policy.

SUBJECT TO CHANGE

The benefit information in this Policy is subject to change, if circumstances arise which require adjustment. Changes will be communicated to members through the mail at least 30 days before the changes are effective. These changes will be incorporated into the next edition of the Policy.

For updates to this Policy, visit us on the web at
http://www.wvinsurance.gov/accesswvpolicyupdates or scan the QR code at the right:

PLAN ADMINISTRATOR and CONTRACTORS

The Plan Administrator for AccessWV is the West Virginia Public Employee's Insurance Agency (PEIA). The Plan Administrator in turn contracts with other organizations, called Third Party Administrators or TPAs, to provide specific services. AccessWV's TPAs are:

HEALTHSMART BENEFIT SOLUTIONS processes applications, bills for premiums, coordinates, adjudicates medical bills, communicates with healthcare providers and members, provides member identification cards, and contracts with specialized TPAs for claims administration, utilization, and case management and pharmacy benefit management.
Eligibility, Application, Medical Benefits, Claims; General Customer Service
Questions call 1-866-864-6142 (toll-free).
www.healthsmart.com

ACTIVEHEALTH reviews services that require Prior Approval, Notification, or Precertification
Pre-service Review
Questions call 1-866-864-6142 (toll-free)

Express Scripts processes claims for all prescription drugs, maintains the Preferred Drug List, and can address specific drug therapy questions.
Questions call 1-877-256-4680 (toll-free)
www.express-scripts.com

Beacon Recovery Group provides subrogation and recovery services for AccessWV.
Questions call 1-800-874-0500 (toll-free)

HOW TO USE THIS DOCUMENT

Being familiar with this Policy will help you get the most from your Plan – in the quickest, easiest way possible. It can also help you avoid a bill for a service that was not covered or was required to be pre-certified or approved in advance.
For these reasons we suggest you:

- Read this Policy as soon as you get it.
- Keep it handy or where you can find it right away. It has many important phone numbers you may need later.
- Refer to it whenever needed, especially if you are going to use health services that are not routine check-ups.

IMPORTANT TERMS

The following terms are used throughout this Policy and are defined below as they pertain to AccessWV:

Allowed Amount: This refers to the basis for payment by AccessWV. For example, for each service covered by AccessWV, the allowed amount is the lesser of the actual charge amount or the maximum fee for the service as set in the Plan Administrator's (PEIA) reimbursement schedule, when the service is received from a WV network provider.

Alternate Facility: A facility other than an acute care hospital.

Annual Benefit: The maximum amount the Plan pays for medical and for pharmacy in a Plan year.

Annual Deductible: The amount you must pay each Plan year before the Plan pays its portion of the cost. Only the Allowed Amounts for covered expenses will be applied to your Deductible. In the case of family coverage, the Family Deductible is divided among the family members. No one person insured on the family policy will pay more than the Individual Deductible.

Balance Billing: The difference between the Charged Amount and Allowed Amount.

Beacon Recovery group (Beacon): The subrogation and recovery vendor for AccessWV. The Plan Administrator (PEIA) contracts with the Beacon Recovery Group for subrogation and recovery services. Beacon pursues recovery of money paid for claims that were not the responsibility of AccessWV. For more information, see the "Recovery of Incorrect Payments" section.

Board of Directors: AccessWV is governed by a seven-person Board. The Board includes the Insurance Commissioner and six members appointed by the Governor. The Board has representation from the insurance and hospital industries and includes persons or relatives of persons who are or could be members of the Plan.

Case Management: See Medical Case Management

Claims Administrator: An organization that processes claims on behalf of AccessWV. HealthSmart and Express Scripts, Inc. are AccessWV's claims administrators. These organizations are contracted by AccessWV's Plan Administrator. See "Medical Claims Administrator" and "Pharmacy Benefit Manager" below.

Coinsurance: The percentage of eligible expenses that you are required to pay after the annual deductible has been met. The amount you pay in coinsurance is applied to your out-of-pocket maximum. You are responsible for paying the coinsurance and deductible amounts directly to the provider of services.

Common Specialty Medications: Specialty medications are high-cost injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of a patient's drug therapy. Under AccessWV, all specialty medications require precertification from Health Smart.

Copay or Copayment: This is the set dollar amount that you pay when you use services. For example, the flat dollar amount you pay for an office visit or the amount you pay for prescription drugs is a copay. Your copays for office visits and other medical services do not count toward your annual medical deductible or annual medical out-of-pocket maximum. Once you reach your pharmacy deductible, your copays for drugs are counted toward your drug out-of- pocket maximum.

Coverage Plan: A health insurance product offered by AccessWV. Plan A, Plan B, Plan C and Plan D are coverage Plans.

Deductible: The amount of eligible expenses you are required to pay each Plan year before the Plan begins to pay benefits. AccessWV has two deductibles: one for medical services and the other for prescription drugs. Copays for office visits do not count toward the medical deductible. Only the allowed amounts for covered expenses will be applied to your Deductible.

Dependent: An eligible person, as determined by AccessWV guidelines, whom the policyholder has properly enrolled for coverage in AccessWV.

Durable Medical Equipment: Medical equipment that is prescribed by a physician which can withstand repeated use, is not disposable, is used for a medical purpose, and is generally not useful to a person who is not sick or injured.

Eligible Expense: A medically necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by AccessWV. For services from West Virginia network providers, allowable expenses under this Plan are calculated according to the Plan Administrator's fee schedules, rates and payment policies in effect at the time of service.

Emergency: An acute medical condition resulting from injury, sickness, pregnancy, or mental illness which arises suddenly and which a reasonable person would believe requires immediate care and treatment to prevent the death, severe disability or impairment of bodily function of the insured. No Prior Approval is necessary, but must be reported within 48 hours.

Exclusion: Services, treatments, supplies, conditions, or circumstances that are not covered under AccessWV.

Experimental, Investigational, or Unproven Procedures: Medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices for a particular case that are determined by AccessWV (at the time it makes a determination regarding coverage in a particular case) to be any of the following:

1. Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Medical Association Drug Evaluations as appropriate for the proposed use.
2. Subject to review and approval by any Institutional Review Board for the proposed use.
3. Subject of an ongoing clinical trial that meets the definition of Phase 1 Clinical Trial set forth in FDA regulations, regardless of whether the trial is actually subject to FDA oversight.
4. Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Explanation of Benefits (EOB): A form sent to the person filing a claim after the claim has been evaluated or processed by the Claims Administrator. The EOB explains the action taken on the claim. This explanation might include the amount paid, benefits available, reasons for denying payment, the member's share of costs, etc.

Express Scripts, Inc.: The pharmacy benefits manager that processes and pays claims for prescription drugs, provides drug information, and carries out drug utilization management functions for AccessWV. Express Scripts is contracted by the Plan Administrator (PEIA) to serve as AccessWV's pharmacy benefits manager.

Federally Defined Eligible Individuals: Persons who have guaranteed access to coverage through the federal Health Insurance Portability and Accountability Act (HIPAA), because they have lost coverage in a group health Plan offered by an employer. Additional requirements apply.

Handicap: A medical or physical impairment which substantially limits one or more of a person's major life activities. The term "major life activities" includes functions such as: care for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning or working. "Substantially limits" means interferes with or affects over a substantial period of time. Minor, temporary ailments or injuries shall not be considered physical or mental impairments which substantially limit a person's major life activities. "Physical or mental impairment" includes such diseases and conditions as orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, autism, multiple sclerosis and diabetes. The term "Handicap" does not include excessive use or abuse of alcohol, tobacco or drugs.

Health Coverage Tax Credit (HCTC) Eligibles: Those who are eligible to enroll in AccessWV because they are eligible for the federal HCTC program. HCTC will pay part of their monthly premiums. They include workers or pensioners displaced by foreign trade, who are certified by the Department of Labor as being HCTC eligible.

HealthSmart Benefit Solutions: The third party administrator that handles medical claim processing, customer service, eligibility and billing.

Inpatient: Someone admitted to a hospital or other facility as a bed patient for medical services.

Insured: Someone who is eligible for and enrolled in AccessWV.

Lifetime Benefits: Maximum lifetime benefit per member is $1 million including all benefits.

Medical Case Management: A process by which AccessWV assures appropriate available resources for the care of a serious long-term illness or injury. ActiveHealth's case management program can assist in providing alternative care plans.

Medical Claims Administrator: The third party administrator that handles medical claims processing, customer service, benefits information and application processing.

Medical Eligibles: Those who are eligible to enroll in AccessWV because they have a pre-existing medical condition that either:

- precludes their enrollment in any other individual health insurance plan within West Virginia; or
- allows enrollment for an insurance product similar to AccessWV but at a higher premium.

Member: A policyholder or dependent who is in a coverage plan offered by AccessWV.

Notification: The required process of reporting an inpatient stay in a West Virginia facility to ActiveHealth. This process is performed to screen for care planning, discharge planning, follow-up care and ancillary service requirements. Failure to notify ActiveHealth may result in increased coinsurance or penalties. All out-of-state facilities require prior approval and notification.

Out-of-Network Provider: A provider who does not participate in AccessWV and does not have contracts with these providers. Using these providers will result in increased coinsurance and penalties.

Out-of-State Network Provider: An out-of-state provider who has a contract with AccessWV. All out-of-state services must receive prior approval.

Outpatient: Someone who receives services in a hospital, alternative care facility, freestanding facility, or physician's office, but is not admitted as a bed patient.

Pharmacy Benefits Manager: The organization that processes and pays claims for prescription drugs, provides drug information, and carries out drug utilization management functions for AccessWV.

Plan: AccessWV.

Plan Administrator: The Plan Administrator for AccessWV is PEIA. PEIA contracts with HealthSmart for eligibility determination, premium billing, member services, claims administration and other functions. The Plan Administrator contracts with other organizations for some of these functions.

Plan Year: The 12-month period beginning July 1 and ending June 30. Member cost-sharing requirements (copays and coinsurance), benefits and limitations are administered on a Plan year basis.

Policyholder: The person who meets the eligibility requirements of AccessWV, enrolls in the Plan, and in whose name the policy is issued.

Precertification: The required process of reporting certain inpatient stays, inpatient and outpatient procedures, and other specified services in advance to obtain approval for the admission, procedure or service. ActiveHealth handles precertification. Failure to obtain precertification results in a penalty that is imposed either on the provider (in the case of West Virginia network providers) or on the member (in the case of an out-of-state service).

Pre-existing Condition: Any physical or mental condition for which medical advice, care or treatment was recommended or received during the six-month period immediately preceding the effective date of coverage in AccessWV.

Premium: The payment required to keep coverage in force.

Prior Approval: The required process of obtaining approval for out-of-state or out-of-network care under the AccessWV Plan; also required for coverage of specialty medications.

Provider Discount: The contracted reduction between a provider's charges and the allowed amount. The AccessWV member is not responsible for the difference between charged amount and allowed amount when the service is provided by a WV provider or by an out-of-state provider who has a contract with AccessWV.

Public Employees Insurance Agency (PEIA): The Plan Administrator for AccessWV; see "Plan Administrator".

Qualified Health Conditions: Conditions for which a person is presumptively eligible for coverage by AccessWV. The forty-seven conditions include Cardiovascular (aneurysm, angioplasty, bypass surgery, congestive heart failure, coronary artery disease, heart attack, heart valve replacement, pacemaker implant, thrombophlebitis, valvular disease); Endocrine/Exocrine System (diabetes); Gastrointestinal (cirrhosis of the liver, Crohn's disease, ulcerative colitis, Hepatitis C); Immunological (AIDS, AIDS-related complex, HIV-positive status, Rheumatoid arthritis, systemic lupus); Kidney (dialysis, renal failure); Musculoskeletal (herniated/degenerative disc, joint replacement, Marfan's syndrome, muscular dystrophy, spina bifida occua, spinal disorders); Neurological (Alzheimer's disease, cerebral palsy, Down's syndrome, Parkinson's disease, stroke, myasthenia gravis, multiple sclerosis, paralysis); Psychiatric (psychosis, attempted suicide); Pulmonary (COPD, cystic fibrosis, emphysema); Other (hemophilia, infertility treated with medications, infertility treated In Vitro or GIFT, Pregnancy, all cancerous conditions within the first five years except basal cell, surgery advised but not yet performed).

Qualifying Changes in Family Status include:

- marriage or divorce;
- death of spouse or dependent;
- birth or adoption of a child;
- a dependent loses eligibility due to age; or
- employment change due to strike or lock-out.

Rational Drug Therapy Program (RDT): The Rational Drug Therapy Program of the WVU School of Pharmacy provides clinical review of requests for drugs that require prior approval under AccessWV. The Plan Administrator contracts for this service on behalf of AccessWV.

Reasonable and Customary: The prevailing range of charges and fees charged by providers of similar training and experience, located in the same area, taking into consideration any unusual circumstances of the patient's condition that might require additional time, skill or experience to treat successfully. AccessWV pays out-of-network providers based on what is "reasonable and customary", when the out-of-network service had prior approval or was provided as emergency care.

Secondary Payer: The Plan or coverage whose benefits are determined after the Primary Plan has paid. See "Coordination of Benefits".

Third Party Administrator (TPA): An organization with which the Plan Administrator contracts to carry out such functions as member services, claims processing and utilization management for AccessWV members. The TPAs for AccessWV are HealthSmart, Express Scripts, and ActiveHealth.

Utilization Management: The general process by which AccessWV controls health care costs. Components of utilization management include precertification of certain inpatient/outpatient surgeries, prior approval of services received outside of West Virginia, notification of all inpatient stays and medical case management. ActiveHealth performs utilization management for AccessWV through a contract with the Plan Administrator.

West Virginia Network Provider: Any West Virginia provider who accepts the PEIA fee schedule is considered an AccessWV network provider.

SECTION 2: ELIGIBILITY & MEMBERSHIP

Individuals are eligible for coverage in AccessWV in several ways:

Federally Qualified by Health Insurance Portability and Accountability Act (HIPPA)

All of the following criteria must be met by an eligible individual:

- Last coverage through a group health plan;
- 18 months of Creditable Coverage substantiated by Certificate of Group Health Insurance Coverage showing the coverage period and last day of coverage;
- Elected and exhausted COBRA or other state continuation coverage, if available, substantiated by letter stating COBRA coverage is ending or employer or insurer statement that COBRA is not available;
- No more than 63 days between last day of plan coverage and date application received by AccessWV;
- Ineligible for Medicare, Medicaid, group health plan or other health insurance coverage;
- Prior coverage not terminated due to non-payment or fraud.

Health Coverage Tax Credit

Individuals are certified eligible by the U.S. Department of Labor (USDOL) for the Health Coverage Tax Credit (HCTC) and must submit the USDOL Notice of Eligibility with their AccessWV application. Waiver of AccessWV's pre-existing condition exclusion period requires at least three (3) months' prior creditable coverage and no more than 63 days between the last day of coverage and application receipt by AccessWV. Documentation of length and end date of prior coverage must accompany application

Medically Eligible

Individuals may be medically eligible for AccessWV insurance in three ways:

- Application to commercial health insurance carrier was denied or coverage limited due to a pre-existing health condition, substantiated by copy of denial letter dated within previous six months;
- Premium quoted for similar health insurance coverage by a commercial insurance carrier was more than the AccessWV premium, substantiated by copy of insurance carrier's letter dated within previous six months;
- Diagnosis of or treatment for a medical or health condition included on AccessWV list of presumptive Qualified Health Conditions.

Exclusion-Period Waiver

The pre-existing period exclusion period may be waived in full or in part for four additional classes of individuals, authorized by statutory amendment and adopted by the Board of Directors for implementation. If an applicant has not satisfied the exclusion period ("waiting period") under previous coverage, AccessWV may waive the portion of the six-month waiting period equal to the waiting period satisfied under previous coverage or in the case of public programs not imposing a waiting period, equal to the previous enrollment in such program.

Eligibility classes are:

- Those previously covered under an individual health insurance policy and who are enrolling in the Plan because premiums for previous coverage were in excess of those changed under the Plan for similar

coverage, without a significant break in coverage; six-month exclusion period is satisfied to the same extent previous coverage's waiting period was satisfied;

- Those previously enrolled in Medicaid, Medicare, the State Children's Health Insurance Program or any other public health insurance program that does not impose a waiting period and is enrolling without a significant break in coverage; six-month exclusion period is satisfied to the same extent of prior public program enrollment;
- Those previously covered under another state's high-risk plan, without a significant break in coverage; six-month exclusion period is satisfied to the same extent previous coverage's waiting period was satisfied;

Those persons without a significant break in coverage who had prior credible coverage of eighteen months or more, regardless of whether that coverage was terminated voluntarily or involuntarily.

When Coverage Starts

Coverage begins on the first day of the month following acceptance of your completed application. This is known as your Effective Date of Coverage. Services received on or after the Effective Date of Coverage may be for considered for payment by AccessWV. Services received prior to your effective date of coverage are not eligible.

In your acceptance letter you were given your member number and Effective Date of Coverage; your identification card will follow. Your identification card is for use with both medical providers and pharmacies.

Annual Residency Survey

Policyholders will receive an annual Residency Survey, which will ask you to provide proof of your continued residency in West Virginia. You can renew enrollment by completing and returning the mandatory survey in the allotted time frame. If the completed survey is not returned by the specified due date, AccessWV will take steps to cancel your enrollment.

Annual Open Enrollment

Policyholders are offered an Open Enrollment period each May. At this time, you are provided information about any changes that will be effective at the start of the new Plan year on July 1. You may change among AccessWV coverage Plans at this time. You may also add dependents to your coverage. These changes will be effective on July 1st. Members who transfer among plans during open enrollment are not subject to pre-existing condition limitations, if they have already met the requirement in AccessWV.

Changing Coverage Plans

Policyholders and enrolled dependents may transfer among AccessWV coverage Plans if:

- Policyholder requests a change during AccessWV's Open Enrollment period, which is held in May. Policyholders will receive information regarding any changes to the coverage Plans at that time. All open enrollment transfers will be effective July 1. All enrolled dependents will also be transferred to the new coverage Plan on that date.
- There is a substantial change in life situation which may include, but is not limited to, a marriage or divorce, death, or the birth or adoption of a child, court-ordered guardianship of a child or dependent adult child, or loss of employer-sponsored health insurance by an eligible dependent.

All requests for transfers submitted in writing on a "Change of Status" form by the 20th of the month will be made effective on the first day of the subsequent month. Changes received after the 20th will be effective the first day of the second subsequent month. For example, if your "Change of Status" form is received on August 10,

the change in your coverage will be effective on September 1, but if your Change Form is received on August 21, the change in your coverage will not be effective until October 1.

Such status changes and the documentation required are shown in the table below, and must be submitted with a Change-in-Status form available from HealthSmart Benefit Solutions. New coverage is effective the first day of the month following enrollment and ending coverage is effective at the end of the month in which they are dis-enrolled.

Status Change Event	Documentation Required
Divorce	Provide a copy of the divorce decree showing that the divorce is final
Marriage	Copy of valid marriage license or certificate
Birth of Child	Copy of child's birth certificate
Adoption	Copy of adoption papers
Adding coverage for a stepchild who resides with the policy holder	Copy of child's birth certificate
Death of spouse or dependent	Copy of death certificate
Change in availability of health insurance through spouse's employment	Employer's letter stating date of termination, retirement, leave of absence, change in employment status date, or other change in availability of coverage

To request a copy of the "Change of Status" form, call HealthSmart at 1-866-864-6142 (toll-free).

DEPENDENTS

Coverage for a policyholder's legal spouse and/or children or others for whom the policyholder has court-appointed guardianship is available through AccessWV. Examples include biological or adopted children or stepchildren. Dependents are eligible for coverage provided they are residents of West Virginia and they meet one of the following requirements:

- Legal spouse with no employer insurance coverage
- Dependent is unmarried and under age 26
- Adult dependent child is incapable of self-sustaining employment by reason of mental or physical disability which began prior to age 16 and is chiefly dependent upon the policyholder for support or maintenance AccessWV may require proof of the incapacity in order for the policyholder to elect to continue the policy in force with respect to the mentally or physically disabled dependent.

Premium rates for those applying for family coverage (i.e. applicant and applicant's spouse and/or dependents) are listed on the "Monthly Premiums" chart included in the AccessWV application packet. Family premium rates are determined by the age, gender and county of residence of the policyholder.

Changes for Dependents

If you wish to add new dependents, such as a new spouse, your biological newborn, or adopted child, you must call the Plan Administrator to request a "*Change of Status*" Form to add them to your coverage. You do not need a Social Security Number to enroll your newborn, but when you obtain a Social Security Number for the child, please provide it to the Plan Administrator. If you wish to add or change coverage for any other dependents, you must submit a "Change of Status" Form to change enrollment.

PRE-EXISTING MEDICAL CONDITIONS

A pre-existing medical condition is any condition for which medical advice, care or treatment was recommended or received during the six-month period immediately preceding your effective date of coverage in AccessWV. In

general, persons who enroll in AccessWV will be subject to a six-month waiting period for pre-existing conditions. The waiting period will also apply to their dependents.

AccessWV will not pay for any services (either medical or pharmacy) related to the pre-existing condition for the first six months of the enrollment. It will pay for services related to a newly experienced injury or illness and for covered preventive care.

If a medical or pharmacy claim is submitted to AccessWV for health services that appear to be related to a pre-existing illness or condition, information will be requested from your provider regarding the diagnosis to determine if the service relates to a condition that you had within the six months prior to your enrollment date.

Persons who qualify for AccessWV in the "medically eligible" category must meet the six-month waiting period for pre- existing conditions.

The pre-existing condition limitation does not apply to persons who qualify for AccessWV as Federally Defined Eligible Individuals or to HCTC eligible persons who have at least 3 months of prior creditable coverage and who have not had a break in coverage of more than 63 days when they apply to AccessWV. For these members, all eligible claims will be paid as of the effective date of coverage.

WHEN COVERAGE ENDS

Certain events will cause AccessWV membership to end for you and/or your covered dependents. Generally, coverage will end if you or a dependent become ineligible for AccessWV coverage. AccessWV coverage for a policyholder and dependents may be terminated by the policyholder as a voluntary termination or by the Plan as an involuntary termination, if the Plan determines certain events have taken place.

Once enrolled, a policyholder will continue to be a member of AccessWV, as long as the policyholder continues to pay the required premiums and answers the annual Residency Survey unless any of the following occurs:

- Policyholder becomes eligible for other individual coverage because his/her condition has improved.
- Policyholder becomes eligible for group coverage through an employer or union.
- Policyholder is no longer a legal resident of West Virginia.
- Policyholder becomes eligible for Medicare, Medicaid or WVCHIP.
- AccessWV pays $1,000,000 in lifetime benefits on behalf of the policyholder.
- Policyholder requests disenrollment in writing.
- Policyholder has committed an act of fraud to circumvent the statutes or regulations of AccessWV.
- Policyholder becomes an inmate of a public institution, which means a Federal/State prison, correctional institution or a Veterans' Home.
- If a policyholder holder is no longer eligible for coverage, coverage of dependents also ends, unless the dependent independently qualifies for membership as a policyholder.

VOLUNTARY TERMINATION

For voluntary terminations, policyholders must provide AccessWV written notice of their intent to disenroll by the 15th of the month for enrollment to cease at the end of that month. Alternatively, coverage will cease at the end of the month in which the policyholder voluntarily ceases to pay premiums.

INVOLUNTARY TERMINATION

AccessWV may cancel coverage for the policyholder and dependents if any of the following occurs:

- Policyholder fails to pay premium when due.
- Policyholder is no longer a resident of West Virginia.
- Policyholder becomes eligible for Medicare, Medicaid, or the WVCHIP.
- Policyholder becomes eligible for similar or more comprehensive policy from another source.
- AccessWV pays a $1,000,000 in lifetime benefits for the policyholder.
- Policyholder dies.
- Annual Residency Survey is not returned by the requested date.
- Policyholder or dependent has committed an act of fraud to circumvent the statutes or regulations of AccessWV.
- Policyholder becomes an inmate or resident of a public institution, which means a federal or state Prison or correctional institution or a Veterans' Home. (Does not apply if the policyholder is a "federally defined eligible individual".)
- State law requires cancellation of the policy.

TERMINATION OF DEPENDENT COVERAGE

Coverage for dependents terminates at the end of the calendar month in which any of the following occurs:

- Policyholder is no longer eligible for coverage.
- Dependent spouse is divorced from policyholder.
- Dependent child reaches 26th birthday.
- Dependent child aged 19-26 becomes eligible for his/her own employer-sponsored health coverage.
- Dependent becomes eligible for Medicare, Medicaid, or WVCHIP.
- Disabled dependent no longer meets disability guidelines.
- AccessWV pays the $1,000,000 maximum in lifetime benefits for the dependent.
- Dependent is no longer a resident of West Virginia.
- Dependent becomes an inmate or resident of a public institution, which means a federal or state prison or correctional facility or a Veterans' home. (Does not apply if the dependent is a "federally defined eligible individual").
- Policyholder voluntarily removes dependent from coverage.

The policyholder is required to report these events and complete the appropriate form to remove ineligible dependents. If the policyholder fails to remove an ineligible dependent, AccessWV may pursue reimbursement of any claims paid for the ineligible dependent from the policyholder. The policyholder may voluntarily terminate coverage for dependents at any time upon written request or by completing a "Change of Status" form.

Upon determination that a member is no longer eligible for AccessWV coverage, the policyholder will receive notification of the termination in the mail at least 30 days before the termination date, except in the case of nonpayment. This notification will include the reason for the termination, date of termination and notice of appeal rights.

In no case will coverage extend beyond the period for which premiums have been paid. If coverage for the policyholder is terminated, coverage for the dependents is also terminated. Members who have terminated coverage for any reason are not eligible to re-apply for AccessWV coverage for 12 months after the cancellation effective date. This restriction does not apply to applicants who are Federally Defined Eligible Individuals or applicants who have exhausted the annual benefit under the West Virginia Children's Health Insurance Program.

YOUR RESPONSIBILITY TO MAKE CHANGES

It is your responsibility to keep your AccessWV enrollment records up to date. You must notify AccessWV immediately of any changes in your family situation and take the necessary steps to keep your AccessWV

coverage up to date. Examples of such changes include a change of address, a change in your marital status, or a dependent child no longer qualifying for coverage. Premiums will be based on the age, gender, geographic location of the policyholder and kind of coverage (individual or family). The policyholder's county of residence will determine which regional premiums are charged.

MEMBER IDENTIFICATION CARDS

You will receive a member identification card within 15 days of your Effective Date of Coverage in AccessWV. Your AccessWV ID card verifies that you have medical and prescription drug coverage under AccessWV. On the back are important telephone numbers you may need. One card will be issued for individual coverage, and two cards will be issued for family coverage. The policyholder's name and identification number will be printed on all cards. If you want additional cards or need to replace a lost card, please contact HealthSmart at 1-866-864-6142 (toll free).

PREMIUMS

By law, AccessWV premiums are based on the price charged by other insurers offering health insurance coverage to individuals in West Virginia. You will receive a notice by mail at least 30 days prior to the effective date of any change in premium.

Premiums are based on age, gender, geographic location of the policyholder and individual or family coverage. The policyholder's county of residence determines which regional premium is charged. The policyholder is solely responsible for notifying the Plan of changes in residence while a member of the Plan. If there is a move which changes the policyholder's premium region, the premium will be adjusted to the new regional rate. If the Plan Administrator is notified of the change by the 20th of the month, the premium will change on the first day of the following month. If the Plan Administrator is notified after the 20th of the month, the premium will change as of the first day of the second following month. Because premiums are structured in five-year age bands, when the policyholder ages into the next age band, the premium will change to reflect the new rate as of the first of the month after the policyholder's birth date.

Premium Billing: Members will be given the option of payment by check, money order or automatic withdrawal from their bank account. For members not on automatic withdrawal, payment coupons will be supplied for submitting with monthly premium checks. Premiums are due by the 1st of each month. NSF checks will incur a penalty fee.

Your coverage as a policyholder, and coverage of your dependents, will terminate if you fail to pay your premium contributions when due. Premiums are due by the 1st day of the month for coverage in that month. If payment is not received within 15 days following the due date, coverage will be cancelled as of the last day of the month for which a premium was paid. A termination letter will be sent.
The policyholder has the right to appeal the termination within 60 days of the termination letter by doing the following:

- Paying the past due premiums and bringing the account up to date, and
- Applying to pay future premiums through direct draft from a bank account.

If this is done, AccessWV will reinstate the policy that has been cancelled for non-payment with no interruption in coverage.

Prohibition against Third-Party Checks: AccessWV does not accept third-party checks for the payment of premiums. All premiums must be paid by the member or the member's spouse, parent or adult child. WV State law prohibits employers from paying premiums for AccessWV coverage in lieu of providing group coverage. It also prohibits providers from paying AccessWV premiums on behalf of patients.

CERTIFICATE OF CREDITABLE COVERAGE

A Certificate of Creditable Coverage will be sent to you upon termination of your coverage in AccessWV. The Certificate provides evidence that you were covered by AccessWV. If you enroll in another health plan, you may be entitled to certain rights if you can demonstrate prior coverage. If you have questions about this Certificate, please call Customer Service at 1-866-864-6142 (toll-free).

SECTION 3: BENEFITS

ANNUAL AND LIFETIME BENEFIT MAXIMUMS

AccessWV will pay a maximum of $1 million in total benefits per person during each member's lifetime, combining both Medical and Drug benefits. When the lifetime maximum has been reached, coverage is terminated by the Plan. If the member is the policyholder, coverage is terminated for the policyholder and dependents. If the dependent reaches the maximum, the dependent will be removed from coverage.

The Annual Benefit Maximum for Medical Benefits is also $1 million. The Annual Benefit Maximum for Prescription Drug benefits is $50,000 per member.

MEDICAL BENEFITS

MEDICAL DEDUCTIBLE

During any Plan year, if you or your eligible dependents incur expenses for covered medical services (other than office visits), you must meet a deductible before AccessWV begins to pay. Medical deductibles are based on whether you get your services within an AccessWV network ("in-network") or outside of the network ("out-of-network"). Your in-network and out-of-network deductibles are shown on your Summary of Benefits.

family deductibles are twice the individual deductibles. The family deductible is divided among the family members. No one member of the family will pay more than the individual deductible. Once the family deductible is met, your coverage plan pays on all members of the family.

For inpatient admissions that span two plan years, the facility charges are paid based on the first plan year, but physician charges are paid based on the date of service, which could be in the first plan year, the new plan year or both plan years. This will affect how the deductible is charged. For example, if you go into the hospital on June 28 and are released on July 6, the hospital bill is paid based on the date of admission, so it would fall under the previous Plan years deductible. Physician charges are paid based on the date of service, so if you have surgery on July 2, the surgeon's bill will be processed based on the new Plan year, which starts July 1. The deductible for the new plan year will apply to the surgeon's bill.

The out-of-network deductible satisfies the in-network deductible, but the in-network deductible does not meet the out- of-network deductible. This means that even if you have met the in-network deductible, you will be responsible for the full out-of-network deductible. The out-of-network deductible is twice the amount of the in-network deductible.

The annual medical deductible will be pro-rated if you first enroll in AccessWV after the first quarter of the Plan year, which runs from July through September. For example, if you first enroll in January, which is in the third quarter of the Plan year, your medical deductible will be half of what the full year deductible would be. Pro-rating will not apply in the case of a change between coverage types (individual and family).

Prescription drug benefits are subject to a separate deductible. This deductible is not pro-rated, and you will be required to meet the annual drug deductible even if you are not covered for the full Plan year. See the "Prescription Drug Benefits" section of this Policy.

COINSURANCE

AccessWV is designed to provide as much care as possible within the State of West Virginia. For many of the services covered by AccessWV, you will pay a coinsurance after you have met the deductible. For services with a coinsurance requirement, your coinsurance percentage is lowest for care received from West Virginia network providers. If you receive the service from a WV network provider, you will pay a 20 percent coinsurance.

If you receive prior approval to receive services out-of-state from a network provider, you will pay 30 percent coinsurance. If you receive prior approval to receive services from an out-of-network provider, you will pay 40 percent coinsurance. If you do not receive prior approval for out-of-state services, your share of costs will increase as your benefit will be subject to a penalty. See "Benefits for Services Received Outside of West Virginia."

Source of Care		Your Coinsurance
West Virginia Network Provider		20%
Out-of-State Network Provider	(with prior approval)	30%
Out-of-Network Provider	(with prior approval)	40%

Your coinsurance payments count toward your annual out-of pocket maximum. Once you reach the out-of-pocket maximum, you no longer pay coinsurance.

COPAYMENTS

Office visits with WV network providers require a copayment only. In these cases, you do not have to meet the deductible for AccessWV to pay for the service. The amounts you pay for copays do not count toward your deductible or your out-of-pocket maximum.

Some services (for example, ambulatory surgery and emergency services) require a copay and coinsurance. In these cases, you will have to meet the deductible and pay the copayment before AccessWV begins to pay its share of the coinsurance.

OUT-OF-POCKET MAXIMUMS

The out-of-pocket maximum is the most you pay in coinsurance in a Plan year. There are separate maximums for medical services and prescription drugs. Once you have met your out-of-pocket maximum, the Plan will pay 100 percent of covered charges (less applicable copayments and special deductibles) for the remainder of the Plan year, until you reach the annual medical benefit maximum or your lifetime combined benefit maximum. Your out-of-pocket maximum amount depends on whether you are enrolled in an Individual or Family Plan and whether you receive services in-network or out-of-network. The out-of-pocket maximums for your Plan are shown in the **Summary of Benefits**.

The family out-of-pocket maximum is twice the individual out-of-pocket maximum. The family out-of-pocket maximum is divided among the family members. No one member of the family will pay more than the individual out-of-pocket maximum. Once the family out-of-pocket maximum is met, AccessWV will pay 100 percent (less applicable copayments and special deductibles) for all family members.
The out-of-pocket maximum for out-of-network services is twice the out-of-pocket maximum for in-network services. Amounts paid toward the out-of-network out-of-pocket maximum count toward the in-network out-of-pocket maximum, but in-network amounts do not count toward the out-of-network maximum.

Amounts you pay toward your annual deductible, your copayments, any precertification or prior approval penalties, your payments for prescription drugs, any amounts billed in excess of what AccessWV pays to out-of-

network providers, and payments for services not covered by AccessWV do not apply toward your annual medical out-of-pocket maximum.

ANNUAL PRESCRIPTION BENEFIT MAXIMUM

Benefits paid under the Prescription Drug Plan have a separate $50,000 per member limit for each Plan year. See the "Prescription Drug Benefits" Section of this Policy.

Six-Month Waiting Period for Pre-Existing Conditions

If you have a pre-existing condition that requires a six-month waiting period before claims will be paid, medical claims may be denied. If coverage is denied due to the waiting period, you will be required to pay the full amount of the claim. This applies only to care received related to your pre-existing condition. Care for new illness or injuries will be paid as outlined.

NETWORK PROVIDERS

AccessWV is a program of the State of West Virginia for West Virginians. AccessWV benefits are designed to encourage the use of health care services within the State. The AccessWV network is made up of West Virginia providers who provide health care services or supplies to AccessWV members. The member's share of costs is lowest when services are received from West Virginia network providers. AccessWV requires prior approval for out-of-state services for the full out-of-state benefit to apply. Even with prior approval the member's share of costs is higher with out-of-state providers. If out-of-state services are received without prior approval, AccessWV's payments are further reduced.

Prior approval for out-of-state services may be granted in the following circumstances:

- The service needed by the member is not available in West Virginia.
- Travel to a WV provider would present an undue hardship.
- Member has an established relationship with an out-of-state provider that should not be disrupted.

ACCESSWV FEE SCHEDULES and RATES

AccessWV pays healthcare providers according to a maximum fee schedule and rates established by the Plan Administrator, PEIA. If a provider's charge is higher than the PEIA maximum fee for a particular service, then AccessWV will allow only the maximum fee. The Allowed Amount for a particular service is the lower of the provider's charge or the PEIA maximum fee.

Any properly licensed West Virginia provider that accepts PEIA reimbursement is considered an AccessWV network provider. In West Virginia, any health care provider who provides services or supplies to an AccessWV member is automatically considered a member of our network. Members are not responsible for any balance billing when services are received from West Virginia providers.

Physicians and other healthcare professionals are paid according to the Resource Based Relative Value Scale (RBRVS) fee schedule. This type of payment system sets fees for professional medical services based on the relative amount of work, practice expense and malpractice insurance expense involved. These rates are adjusted annually. West Virginia physicians who treat AccessWV members must accept PEIA's allowed amount as payment in full. They may not bill additional amounts to AccessWV members.

AccessWV also pays hospitals following the PEIA methodology. Most inpatient hospital services are paid on a "prospective" basis. PEIA's reimbursement to hospitals is based on Diagnosis-Related Groups (DRGs), which is the system used by Medicare. It is a Prospective Payment System (PPS) that classifies medical cases and surgical

procedures on the basis of diagnoses. Under this system, West Virginia hospitals know in advance what PEIA (and AccessWV) will pay per day or per admission. West Virginia hospitals have been provided specific information about their reimbursement rates from PEIA. These rates are adjusted annually. West Virginia hospitals that treat AccessWV members must accept PEIA's allowed amount as payment in full.

Many outpatient services are also paid on a prospective basis. PEIA has adopted a modified version of Medicare's Outpatient Prospective Payment System (OPPS). OPPS reimbursement is based on Ambulatory Payment Classification (APC) Groups. APC's include groups of services that are similar clinically and require similar resources. These rates are adjusted annually.

OUT-OF-STATE NETWORK PROVIDERS

AccessWV, through the Plan Administrator, has a contract with Aetna Signature Administrators PPO providers. To locate a network provider, call HealthSmart at 1-866-864-6142 (toll-free). When it is necessary for members to receive services out-of- state, this contract enables AccessWV to enjoy more favorable rates, which are, in turn, passed on to the members.

In general, a member pays a 30 percent coinsurance when AccessWV grants prior approval for services from these providers. Members are responsible for any copays or deductibles associated with the service. Please see your Summary of Benefits for details. If a member elects to receive services out-of-state from one of the network providers without prior approval, the member's coinsurance increases to 50 percent and there is an additional $1,000 penalty for inpatient care. The prior approval requirement does not apply to Emergency Care.
If you receive medical attention from a provider in an out-of-state network, your claim will be sent to HealthSmart. AccessWV pays all out-of-state network providers directly for its share of costs. You will pay your share of costs directly to the providers. This includes deductibles, copayments, coinsurance amounts and amounts for non-covered services. When your claim is paid, HealthSmart will send you an Explanation of Benefits (EOB).

Not all hospitals in these networks may participate with AccessWV. AccessWV reserves the right to remove providers from the networks, so not all providers in these networks may be available. In addition, the medical claims administrator contracts with some additional out-of-state providers, to serve AccessWV members. For further information on out-of-state network providers, call HealthSmart at 1-866-864-6142 (toll-free).

OUT-OF-NETWORK PROVIDERS

AccessWV does not have contracts with out-of-network providers. When AccessWV grants prior approval for services from these providers, the member pays 40 percent coinsurance after the out-of-network deductible and is responsible for any copays or additional deductibles associated with the services. See your Summary of Benefits for details. In this situation, AccessWV pays based on the "reasonable and customary" allowance, which may be less than the provider's charges.

If a member elects to receive services from an out-of-network provider without prior approval, AccessWV's basis for payment changes from the "reasonable and customary" amount to the PEIA fee schedule. Member is liable for the difference between billed charges and the PEIA schedule ("balance billing").

CLAIMS INCURRED OUTSIDE OF THE U.S.A

If you or a covered dependent incur medical expenses while outside the United States, you may be required to pay the provider yourself; request an itemized state of services. For reimbursement, call HealthSmart to request a claim form. Complete and submit as directed by HealthSmart.

BENEFIT DESIGN

Services Covered in Full

The following services are covered in full when received from a West Virginia network provider.

Service	Cost with WV Network Providers
Routine prenatal care (physician services)	$0, Covered in full
Well child exams and immunizations as recommended by the American Academy of Pediatrics	$0, Covered in full
High risk birth score program	$0, Covered in full
Annual screening mammogram	$0, Covered in full
Annual Pap Smear[1]	$0, Covered in full
Colorectal cancer screening age 50 + above[1]	$0, Covered in full
Prostate cancer screening age 50 + above[1]	$0, Covered in full
Abdominal Aortic Aneurysm one-time screening from men age 65 – 75 who have ever smoked	$0, Covered in full
Cholesterol Screening for men age 35 and older and women age 45 and older or others at higher risk	$0, Covered in full
Tobacco Use screening for all adults and cessation interventions for tobacco users (excludes tobacco cessation medications	$0, Covered in full
HIV screening for all adults at higher risk	$0, Covered in full
Immunization vaccines recommended for adults doses, recommended ages and recommended populations vary	$0, Covered in full
Syphilis screening for all adults at higher risk	$0, Covered in full
Anemia screening on a routine basis for pregnant women	$0, Covered in full
Bacteriunia urinary tract or other infection screening for pregnant women	$0, Covered in full
BRAC counseling about genetic testing for women at higher risk	$0, Covered in full
Hepatitis B screening for pregnant women at their first prenatal visit	$0, Covered in full
Osteoporosis screening for women over age 60 depending on risk factors	$0, Covered in full
RH Incompatibility screening for all pregnant women and follow-up testing for women at higher risk	$0, Covered in full
Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea and Syphilis to women at increased risk	$0, Covered in full
Alcohol and drug use assessments for adolescents	$0, Covered in full
Autism Screening for children at 18 and 24 months	$0, Covered in full
Behavioral assessments for children of all ages	$0, Covered in full
Cervical Dysplasia screening for sexually active females	$0, Covered in full
Congenital Hypothyroidism screening for newborns	$0, Covered in full
Development screen for children at higher risk of lipid disorders	$0, Covered in full
Dyslipidemia screening for children at higher risk of lipid disorders	$0, Covered in full
Gonorrhea preventive medication for the eyes of all newborns	$0, Covered in full
Hearing screening for all newborns at birth	$0, Covered in full
Height, Weight and Body Mass Index measurements for children	$0, Covered in full
Hematocrit or hemoglobin screening for children	$0, Covered in full
Hemogloinopathies or sickle cell screening for newborns	$0, Covered in full
Lead screening for children at risk of exposure	$0, Covered in full
Medical History for all children throughout development	$0, Covered in full
Obesity screening and counseling (does not include the PEIA Weight Management Program)	$0, Covered in full
Oral Health risk assessment for your children	$0, Covered in full

[1] Testing covered in full; $10 preventive care office visit copay may apply.

Services with Copayments Only: When received from a WV network provider, the following services require only a copayment and are not subject to the deductible.

Service	Cost with WV Network Providers
Physician office visit – preventive care	$10 copay per visit
Physician office visit – for illness or injury	$15 copay per visit
Specialist office visit	$25 copay per visit
Adult routine physical exams	$10 copay per visit
Second surgical opinion*	$15 copay per visit

* No copay if required by HealthSmart

Services Requiring a Copayment, Deductible and Coinsurance: When received from a WV network provider, the following services require that the deductible be met before the Plan begins to pay. Once the deductible is met, a copayment applies and the balance is subject to coinsurance.

Service	Cost with WV Network Providers
Emergency services including supplies (certified as emergency)	$25 copay + 20% coinsurance after the in-network deductible
Emergency room treatment (non-emergency)	$50 copay + 20% coinsurance after the in-network deductible
Ambulatory/outpatient surgery	$50 copay + 20% coinsurance after the in-network deductible

Services Requiring Deductible and Coinsurance: Generally, services not listed in the above three charts are covered at 80 percent after you have met the in-network deductible, when they are received from WV network providers. Your share is 20 percent coinsurance.

Limits on Specific Benefits: Benefit limits apply to certain services covered by AccessWV. See below.

Service	Benefit Limit (Per Member Per Plan Year)
Outpatient mental health/chemical dependency*	20 visits
Christian Science treatment	$1,000
Outpatient therapies (including Massage Therapy, Chiropractic,	20 visits (total for all therapies combined)
Physical Therapy, Occupational Therapy and/or Acupuncture)	150 days
Inpatient rehabilitation	100 days
Skilled nursing facility	30 days
Inpatient mental health/chemical dependency*	36 sessions

* May be extended if approved by HealthSmart.

Members experiencing a severe medical episode and members with complicated medical conditions are assigned a nurse case manager. For these catastrophic cases, the case manager may, based on medical documentation, recommend additional treatment for services marked with an asterisk.

PRECERTIFICATION, NOTIFICATION, and PRIOR APPROVAL REQUIREMENTS

Certain medical services require precertification, meaning a review to determine whether they are medically necessary and to evaluate the need for case management. Other services require Notification in order to determine if the patient's medical condition will require case management, such as discharge planning for home healthcare services. Prior Approval is required for non-emergency services received out-of-state, whether or not they require precertification or notification. Review of the request will consider the justification offered, as well as medical necessity and need for case management. The AccessWV member who wishes to receive services out-of-state is responsible for requesting prior approval.

Precertification of Inpatient Admissions and Certain Outpatient Services (Required)

Precertification must be requested 3 or more days in advance of a scheduled procedure by calling ActiveHealth at 1-866-864-6142 (toll-free). Failure to pre-certify scheduled services will incur a 30% penalty. If the procedure is determined not to have been medically necessary, it may not be covered. In the absence of required precertification, i.e. for services not requiring precertification, Notification is required to evaluate the planned admission to determine if case management is required, such as discharge planning for home health services. If a service has been pre-certified, notification is not necessary.

Notification is required for the following facility admissions:

1. Medical (non-surgical),
2. Surgical admissions (except those specifically listed as requiring precertification),
3. Emergency (including chest pain, congestive heart failure, and other cardiac events), and
4. Maternity and newborn.

TIMELY PRECERTIFICATION AND NOTIFICATION

Failure to pre-certify or notify ActiveHealth within specified timeframes shown in the following table will result in reduction of benefits of 30 percent. This 30% penalty will be the responsibility of network providers. For all non-network providers, this penalty will be the responsibility of the member in addition to any applicable copayment, coinsurance, deductible, and amounts that exceed AccessWV's maximum allowance. If the member or provider feels that extenuating circumstances prevented notification or precertification within these timeframes, the member or provider may file an appeal. See "Your Rights to Appeal Decisions Made by AccessWV".

Timely Precertification Requirements	
Type of Admission	Advance Notice Required
Scheduled:	
Planned admission	3 business days in advance
Inpatient elective surgery or procedure	3 business days in advance
Maternity (notify ActiveHealth during your first trimester)	
Term pregnancy	Within 48 hours of admission
Caesarean section (planned)	3 business days in advance
Caesarean section (emergency)	Within 48 hours of admission
Urgent/Emergency	Within 48 hours of admission
Extended stay	Additional days may be recommended based on medical necessity

Outpatient Services Requiring Precertification
• Any potentially experimental/investigational procedure, medical device, or treatment
• Artificial disc surgery
• Bariatric surgery (lap band)
• Cochlear implants
• Continuous glucose monitors
• CT scan of sinuses or brain
• CTA (CT Angiography)
• Dialysis Services

Outpatient Services Requiring Precertification
• Discectomy with spinal fusion surgery
• Durable medical equipment purchases and/or rentals of $1,000 or more
• Elective (non-emergent) air ambulance transportation
• Elective and cosmetic surgery such as breast reduction, blepharoplasty, abdominoplasty, breast reconstruction, and treatment of varicose veins
• Hyperbaric oxygen therapy (HBOT)
• Hysterectomy
• Implantable devices such as implantable pumps, spinal cord stimulators, neuromuscular stimulators, and bone growth stimulators
• IMRT (intensity modulated radiation therapy)
• Laminectomy
• Laminectomy with spinal fusion
• Limited Molecular Diagnostic/Genetic Testing to include the following 5 tests: Hereditary Non-polyposis Colorectal Cancer (HNPCC) testing, BRCA gene testing, Oncotype DX, Familial Adenomatous Polyposis (FAP testing, Catecholaminergic Polymorphic Ventricular Tachycardia (FPVT) testing.
• MRI scan of knee and spine (includes cervical, thoracic, and lumbar)
• Partial/Day mental health and substance abuse treatment programs
• Services in the home as described under “Medical Case Management”
• Sleep studies, services and equipment (see “Sleep Management” section on page 40.)
• SPECT (single photon emission computed tomography) of brain and lung
• Spinal fusion surgery
• Transplants
• Uvulopalatopharyngoplasty

Inpatient Services Requiring Precertification
• All admissions to out of state hospitals and facilities
• Artificial intervertebral disc surgery
• Bariatric surgery (gastric bypass, lap band, sleeve, etc.)
• Cochlear implants
• Discectomy with spinal fusion surgery
• Elective and cosmetic surgeries such as breast reduction, blepharoplasty, abdominoplasty, breast reconstruction, and surgery for varicose veins
• Hysterectomy
• Insertion of implantable devices such as implantable pumps, spinal cord stimulators, neuromuscular stimulators, and bone growth stimulators
• Laminectomy
• Laminectomy with spinal fusion surgery
• Mental health and substance abuse treatment
• Spinal fusion surgery
• Transplants and transplant evaluations such as kidney, liver, heart, lung, pancreas, small bowel, and bone marrow replacement or stem cell transfer after high dose chemotherapy
• Uvulopalatopharyngoplasty

NOTIFICATION REQUIRED

For services that do not require Precertification, Notification provides the opportunity for AccessWV to evaluate the admission to determine if the patient's medical condition will require case management, such as discharge planning for home health services.
Notification to ActiveHealth is required for the following inpatient admissions to West Virginia facilities:

- medical (non-surgical)
- surgical admissions (except those specifically listed as requiring precertification since the precertification triggers the "notification")
- emergency (including chest pain and congestive heart failure, and other cardiac events)
- maternity and newborn

Failure to notify ActiveHealth of an inpatient admission within the time frames specified in the chart below will result in a reduction of benefits under AccessWV of 30 percent. This penalty will be the responsibility of WV network providers.

PRIOR APPROVAL FOR OUT-OF-STATE SERVICES (REQUIRED)

An AccessWV member who wishes to receive services out-of-state must request prior approval for full benefits to apply to such services. Emergency care is not subject to this requirement. Prior approval may be granted if the service cannot be received within West Virginia, if travel to the West Virginia service would present an undue hardship or member has an established relationship with an out-of-state provider that should not be disrupted. If a member fails to request prior approval and receives a service out-of-state that requires precertification; for example, inpatient mental health services, a penalty will apply for the failure to obtain prior approval as well as a 30 percent penalty for failure to pre-certify. In this situation, a service may not be covered at all, if AccessWV determines that it was not medically necessary.

A request for prior approval is made by calling ActiveHealth at 1-866-864-6142 (toll-free). The request should be made as soon as a member knows they wish to receive services out-of-state, and no later than 5 days before the expected date of service. If the member or provider feels AccessWV inappropriately refused to grant prior approval for services to be received out-of-state, a member or provider may file an appeal. See "Your Right to Appeal Decisions Made by AccessWV."

A request for prior approval of out-of-state services triggers consideration of medical necessity if the planned procedure requires precertification. The prior approval request also triggers consideration of the network status of the proposed provider. With prior approval, services from an out-of-state provider who is IN-NETWORK requires 30% coinsurance, whereas services from an out-of-state provider who is OUT-OF-NETWORK requires 40% coinsurance. Where prior approval has not been sought or has not been granted, significant penalties apply, as shown in the chart below.

Provider		Prior Approval	Coinsurance after Deductible
In-state	In-Network		20%
Out-of-State	In-Network	Prior approval	30%
Out-of-State	In-Network	NO prior approval	40% + balance billing
Out-of-State	Out-of-Network	Prior approval	40%
Out-of-State	Out-of-Network	NO prior approval	+ balance billing (plan allowance = in-state fee schedule)

Out-of-State In-Network Providers	Penalty without Prior Approval
All Services (except Emergency Care)	Plan's share of coinsurance drops from 70% to 50%.
Inpatient Hospital Care	Reduction in Plan's share of coinsurance as noted above + $1,000 penalty payable by member.
All Services	Plan's basis for payment changes from "reasonable and customary" to the WV in-state fee schedule used by AccessWV. Member is liable for the difference between billed charges and the plan payment ("balance billing.")

If the insured or provider feels that ActiveHealth inappropriately refused to grant approval for services to be received out-of-state, the member or AccessWV may file an appeal.

OTHER PRE-SERVICE REVIEW Preapproval (Voluntary)

Preapproval is a voluntary program which allows you to contact ActiveHealth in advance of a procedure to verify that the service is covered and that it will be paid so that you can make an informed decision about the procedure. Obtaining preapproval assures that your claim will be paid when it is submitted. To obtain preapproval, ask your provider to call:

ActiveHealth
1-866-864-6142

Your provider should include your name, address, telephone number, your member identification number, and all information about the recommended procedure. ActiveHealth may contact your physician for more information. Remember, if your request for preapproval is denied, you will be responsible for paying for the procedure, if you choose to have it. Due to specific benefit criteria, preapproval is recommended for the following procedures:

- Accident-related Dental Services
- Chelation Therapy
- Chiropractic Services under age 16
- Massage Therapy
- Oral Surgery
- Orthotics
- Vision Therapy

MEDICAL CASE MANAGEMENT

If you are experiencing a serious or long-term illness or injury, ActiveHealth's medical case management program can help you learn about available resources, provide early support for your family, and find ways to contain medical costs, including your out-of-pocket expenses. Through case management, ActiveHealth can:

- arrange home care to prevent hospitalization
- arrange services in the home to facilitate early hospital discharge
- obtain discounts for special medical equipment
- locate appropriate services to meet the patient's health care needs
- for catastrophic cases, when medically proven as a part of a comprehensive plan of care, allow additional visits for outpatient mental health or Outpatient Therapy Services; and
- under very limited circumstances, allow additional visits for short-term outpatient physical therapy services for treatment of a separate condition which is also a new incident or illness—not an exacerbation of a chronic illness.
- For example, a member who receives physical therapy following a stroke and later in the Plan Year has a separate new condition, such as a broken leg, may receive coverage for additional physical therapy visits.

For catastrophic cases involving serious long-term illness or injury resulting in loss or impaired function requiring medically necessary therapeutic intervention, the ActiveHealth case manager may, based on medical documentation, recommend additional treatment for certain therapy services. For details of these benefits, see "What Is Covered" later in this section.

ActiveHealth must be notified for medical case management for the following services:

- home health care, including but not limited to:
- skilled nursing of more than seven (7) visits
- I.V. therapy in the home
- physical therapy, occupational therapy or speech therapy done in the home
- medication provided or administered by a home health agency
- hospice care
- skilled nursing facility services
- rehabilitation service.
- treatment for Autism Spectrum Disorder

WHAT IS COVERED

MEDICALLY NECESSARY SERVICES

Covered services must be medically necessary or be one of the specifically listed preventive care services covered by AccessWV.

Medically necessary health care services and supplies are those provided by a hospital, physician or other licensed health care provider to treat an injury, illness or medical condition. A service is considered medically necessary, if it is:

- consistent with the diagnosis and treatment of the illness or injury;
- in keeping with generally accepted medical practice standards;
- not solely for the convenience of the patient, family or health care provider;
- not for custodial, comfort or maintenance purposes;
- rendered in the most cost-efficient setting and level appropriate for the condition; and
- not otherwise excluded from coverage by AccessWV.

The fact that a physician has recommended a service as medically necessary does not make the charge a covered expense. AccessWV reserves the right to make the final determination of medical necessity based on diagnosis and supporting medical data.

Who May Provide Services

AccessWV will pay for covered services rendered by a health care professional or facility if the provider is:

- licensed or certified under the law of the jurisdiction in which the care is rendered; and
- providing treatment within the scope or limitation of the license or certification; and
- not under sanction by Medicare, Medicaid or both. Services by providers under sanction will be denied for the duration of the sanction; and
- not excluded by AccessWV due to adverse audit findings.

Types of Medical Services Covered

AccessWV covers a wide range of health care services. Some major categories are listed below. The description

of each service includes the level of coinsurance and any applicable copayments you must pay when the service is received from a West Virginia network provider.

Services you receive outside of West Virginia from network providers ("out-of-state network providers") or from out-of- network providers are subject to higher levels of coinsurance, may require higher copays or additional deductibles, and require prior approval, except in the case of an emergency. See "Benefits for Services Received Outside of West Virginia" for details.

If you have questions about coverage of services, call HealthSmart at 1-866-864-6142 (toll-free).

Covered Services (Alphabetical List)	
Service	**Information**
Allergy Services	Including testing and related treatment; in-network care covered at 80% after in-network deductible is met.
Ambulance Services	Emergency ground or air ambulance transportation, when medically necessary, to the nearest facility able to provide needed treatment. Services from WV network providers are covered at 80 percent after the in-network deductible is met. Non-emergency transportation is not covered.
Ambulatory Surgery ("Outpatient Surgery")	When performed in a WV network hospital or alternative facility, this service is covered at 80 percent after the in-network deductible and a $50 copay are met. When performed in a WV network physician's office, the $50 copay does not apply. Certain ambulatory surgical procedures require precertification.
Autism Spectrum Disorder	Applied behavior analysis (ABA) services, to the extent mandated by W. Va. Code § 5-16-7(a)(8), when provided in-network are covered at 80% after deductible is met.
Bariatric surgery	This benefit is subject to $500 copayment and 20% coinsurance. The copayment and coinsurance amounts apply after in-network deductible has been met. Must meet plan guidelines.
Cardio or Pulmonary Rehabilitation	Benefits are limited to 3 sessions per week for 12 weeks or 36 sessions per member per Plan year for the following conditions: heart attack in the 12 months preceding treatment, heart failure, coronary by-pass surgery or stabilized angina pectoris. Covered at 80 percent from WV network providers after the in-network deductible is met.
Chelation Therapy	Benefits for these services are limited. Contact HealthSmart to see if coverage will be provided. If covered, therapy from a WV network provider is paid at 80 percent after the in-network deductible is met.
Childhood Immunizations	Immunizations, as recommended by the American Academy of Pediatrics, for children Immunizations through age 16 are covered at 100 percent of allowed charges, including the office visit. This benefit does not require a deductible, coinsurance, or a copayment. See also "Immunizations".
Chiropractic Services	Services of a chiropractor for acute treatment of neuromuscular-skeletal conditions are included in the "Outpatient Therapies" benefit (see below). Combined coverage for these therapies is limited to a maximum of 20 visits per member per Plan year. Office visits with WV network providers are covered with a $15 copay. X-rays with WV network providers are covered at 80 percent after the in-network deductible. Maintenance services are not covered. Voluntary preapproval is recommended for services for children under age 16.

<table>
<tr><th colspan="2">Covered Services (Alphabetical List)</th></tr>
<tr><th>Service</th><th>Information</th></tr>
<tr><td>Christian Science Treatment</td><td>Treatment for a demonstrable illness or injury if provided in a facility accredited by the Commission for Accreditation of Christian Science Nursing Facilities/Organizations, Inc. or by a practitioner accredited by the Mother Church is covered at 80 percent after the in-network deductible. No benefits will be paid for the purpose of rest or study, for communication costs, or if the person requiring attention is receiving parallel medical care. Coverage is limited to a maximum cost to the Plan of $1,000 per Plan year. If required, this benefit may be extended for inpatient care for up to 60 days per Plan year. Inpatient care must be pre-certified.</td></tr>
<tr><td>Colorectal Cancer Screenings</td><td>This benefit is covered as follows: Routine screening to detect colorectal cancer is covered at 100% in-network with no deductible or coinsurance required. The related office visit expenses are subject to the applicable preventive care office visit copay.
<table>
<tr><td>Fecal-Occult Blood Test</td><td>1 in 12 months for ages 50 and over</td></tr>
<tr><td>Flexible Sigmoidoscopy</td><td>1 in 5 years for ages 50 and over</td></tr>
<tr><td>Colonoscopy for High Risk</td><td>1 in 24 months for high risk patients*;</td></tr>
<tr><td>X-Ray, Barium Enema</td><td>1 in 5 years for ages 50 and over</td></tr>
<tr><td>X-Ray, Barium Enema</td><td>1 in 24 months for high risk patients*</td></tr>
</table>
*High risk is defined as a patient who faces high risk for colorectal cancer because of family history; prior experience of cancer or precursor neo-plastic polyps; history of chronic digestive disease condition (inflammatory bowel disease, Crohn’s disease, ulcerative colitis); and presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors.</td></tr>
<tr><td>Cosmetic/Recon-structive Surgery</td><td>Services provided when required as a result of accidental injury or disease or when performed to correct birth defects are covered at 80 percent from WV network providers after the in-network deductible is met. Other cosmetic or reconstructive surgery is not covered.</td></tr>
<tr><td>Dental Services (Accident-Related Only)</td><td>Services provided within six (6) months of an accident and required to restore tooth structures damaged due to that accident are covered at 80 percent with WV network providers after the in-network deductible is met. The initial treatment must be provided within 72 hours of the accident. Biting and chewing accidents are not covered. Services provided more than six (6) months after the accident are not covered. The Least Expensive Professionally Acceptable Alternative Treatment (LEPATT) for accident-related dental services will be covered. For example, the dentist may recommend a crown, but AccessWV will only provide reimbursement for a large filling. Contact HealthSmart TPA for more information. For children under the age of 16, the six-month limitation may be extended if an approved treatment plan is provided to HealthSmart within the initial six months.</td></tr>
<tr><td>Dental Services (Impacted Teeth)</td><td>Medically necessary extraction of impacted teeth is covered at 80 percent from WV network providers after the in-network deductible is met. Extractions for the purpose of orthodontia are not covered.</td></tr>
<tr><td>Dexa Scans</td><td>Bone mass measurement by DEXA is limited to one scan every 24 months for members who meet at least one of the following criteria:
Member has received results from a peripheral osteoporosis screen indicating moderate or high risk for osteoporosis.
Member has documented clinical risk for osteoporosis.
Diagnostic testing is covered at 80 percent with WV network providers after the in-network deductible is met. Routine screening scans are not covered. For additional information contact HealthSmart at 1-866-864-6142 (toll-free).</td></tr>
</table>

Covered Services (Alphabetical List)	
Service	**Information**
Diabetes Education	Services of a diabetes education program that meets the standards of the American Diabetes Association are coved at 80% after in-network deductible is met. Coverage is limited to six (6) visits per patient: three visits with the dietician and three visits with a registered nurse. Contact HealthSmart for specific benefit limitations.
Dietician Services	Services of a licensed, registered dietician are covered with the appropriate office visit copayment. Coverage is limited to two visits per year when prescribed by a physician for adult members with the following conditions: hypertension, hyperlipidemia, heart disease, kidney disease, and metabolic syndrome. Diabetic patients see Diabetes Education above. Benefit may be extended to children who meet criteria.
Durable Medical Equipment (DME) and Prosthetics	Coverage for the initial purchase and reasonable replacement of standard implant and prosthetic devices, and for the rental or purchase (at the plan's discretion) of standard DME, when prescribed by a physician. Prosthetics and DME purchases of $1, 000 or more, or rental for more than 3 months must be pre-certified by ActiveHealth, DME and prosthetics are covered at 80% after the in-network deductible is met. Omnipod and other disposable insulin delivery systems are not covered.
Emergency Services (Including Supplies)	Services received in an emergency room when the condition has been certified as an emergency are subject to a $25 copay and are covered at 80 percent after the in-network deductible is met.
Home Health Services	Intermittent health services of a home health agency when prescribed by a physician are covered at 80% after the in-network deductible is met. Services must be provided in the home, by or under the supervision of a registered nurse. The home health services are covered only if they would otherwise have required confinement in a hospital or skilled nursing facility. If more than twelve (12) visits are necessary, precertification is required.
Hospice Care	When ordered by a physician; covered at 80% after the in-network deductible is met.
Hyperbaric Oxygen Therapy	Covered at 80% after the in-network deductible is met.
Hypertension Screening	AccessWV pays for diagnostic screening to determine if you are at risk for high blood pressure, heart disease or stroke. Benefits include coverage for an office visit, blood pressure check, and a blood chemistry profile. With a WV network provider, the office visit is subject to a $10 "Preventive Care" copay. The blood chemistry is covered at 80 percent after the in-network deductible is met. The blood pressure check is included as part of the office visit. AccessWV will pay for this screening according to the following schedule: One time between the ages of 20 and 30 Once every three years between ages 31and 39 Once every two years after age 40.
Immunizations	• For children through age 16, the plan covers immunizations and the associated office visit with no deductible, coinsurance, or copayment required. Also see "Well Child Care." • For adults and children over age 16, the plan covers immunizations administered in a physician's office as recommended by the American Academy of Family Physicians at 100% in network. The associated office visit is subject to the applicable copayment. Other immunizations are covered at 20% coinsurance after the in-network deductible is met. If purchased at a pharmacy, the member will be reimbursed according to PEIA's fee schedule.

Covered Services (Alphabetical List)	
Service	**Information**
	• Flu and Pneumonia vaccines administered in a retail pharmacy are a covered benefit and will be paid as a medical benefit; not a pharmacy benefit. • Adults and Children Ages 17 and Over. AccessWV covers immunizations as recommended by the American Academy of Family Physicians and the American Academy of Pediatrics at 100 percent with no deductible or coinsurance required, when received from WV network providers. The associated office visit is subject to the applicable copay. Other immunizations when received from WV network providers are covered at 80 percent after the in-network deductible is met.

Age Range	Vaccine
Birth - 2 months	Hepatitis B
1 – 4 months	
6 – 18 months	If missed, get 3 doses starting at age 11 years
2 months	Rotavirus
4 months	
6 months, depending on vaccine used	
2 months	Haemophilus Influenza Type B
4 months	
6 months	
12 – 15 months	
Or 2 months, 4 months, and 12 – 15 months, depending on vaccine type	
2 months	Pneumococcal Disease (PrevnarTM)
4 months	
6 months	
12 -15 months If missed, talk to your healthcare provider	
2 months	Diphtheria-Tetanus-Pertussis (DTaP)
4 months	
6 months	
15 – 18 months	
4 – 6 years	
2 months	Polio (IPV)
4 months	
6 months	
15 – 18 months	
4 – 6 years	
Begin at 6 months, with 2nd dose at least 6 months apart	Hepatits A
6 months and then annually	Influenza

Age Range	Vaccine
12 -15 months	Varicella
4 – 6 years	
12 – 15 months	Measles-Mumps-Rubella (MMR)
4 – 18 years	
2 - 10 years of certain children	Meningococcal
Unvaccinated college freshmen	
11 – 18 years with booster every 10 years	Tetanus-Diphtheria (TD)
11 – 26 years –Male & Female	Human Papillomavirus (HPV)

Inpatient Hospital and Related Services	Confinement in a hospital including semi-private room, special care units, confinement for detoxification, and related services and supplies during the confinement are covered at 20% coinsurance after the in-network deductible is met. All unapproved out-of-network inpatient admissions are subject to a $500 copayment per admission.
Inpatient Medical Rehabilitation Services	When ordered by a physician, coverage is subject to 20% coinsurance after the in-network deductible is met and is limited to 150 days per plan year. All unapproved out-of-network inpatient admissions are subject to a $500 copayment per admission.
Intensive Modulated Radiation Therapy (IMRT)	Covered at 80% after the in-network deductible is met.
Mammogram	An annual routine mammogram to detect breast abnormalities is covered at 100 percent when received from a WV network provider with no coinsurance or deductible required. The related office visit expenses are subject to the applicable copayment. When billed with a medical diagnosis (instead of as a screening test), it is considered a diagnostic test, and the deductible and 20% coinsurance will apply.
Massage Therapy	Therapeutic services of a licensed massage therapist for treatment of neuromuscular-skeletal conditions are covered under the Outpatient Therapy Benefit when ordered by a physician. Covered at 80% after the in-network deductible. Initial 20 visits require a $10 copayment per visit. Visits 21 +, if approved by ActiveHealth, require a $25 copayment per visit. Combined coverage for these therapies is limited to a maximum of 20 visits per person per plan year. See Outpatient Therapy Services for more information.
Mastectomy	If you are receiving benefits in connection with a mastectomy due to cancer and elect breast reconstruction in connection with such benefits, you are entitled to the following: • Reconstruction of the breast on which the mastectomy was performed; • Reconstructive surgery of the other breast to present a symmetrical • appearance; and • • Prostheses and coverage for physical complications at all stages of the mastectomy procedure including lymphedas.
Maternity	See “Maternity Care” under special care for details.
MRA	Magnetic Resonance Angiography services when performed on an outpatient basis by a WV network provider are covered at 80 percent after the in-network deductible is met.

MRI	Magnetic Resonance Imaging services when performed on an outpatient basis, are covered at 80% after the in-network deductible is met.
Mental Health Services: Inpatient Care	Inpatient and outpatient partial hospitalization day programs for mental health and chemical dependency services are limited to a maximum of 30 days per member per Plan year. For outpatient partial/day programs, two (2) outpatient days are counted as one (1) inpatient day when applying the 30 day maximum. Catastrophic cases will be assigned to a nurse case manager. For these extreme medical conditions, the case manager may, based on medical documentation, recommend additional treatment. These services, when received from a WV network provider, are covered at 80% after the in-network deductible is met.
Mental Health Services: Outpatient Care	Outpatient mental health, chemical dependency and substance abuse services are limited to a maximum of 20 visits per plan year for short-term individual and/or group outpatient mental health and chemical dependency services. This benefit includes evaluation and referral, diagnostic, therapeutic, and crisis intervention services performed on an outpatient basis (including physician's office). Catastrophic cases will be assigned a nurse case manager. For these extreme medical conditions, the case manager may, based on medical documentation, recommend additional treatment beyond 20 visits. This benefit is covered at 80% after the in-network deductible is met.
Neuromuscular Stimulators and Bone Growth Stimulators	With a WV network provider, these are covered at 80% after the in-network deductible is met.
Oral Surgery	Coverage limited to extraction of impacted teeth, orthognathism and medically necessary ridge reconstruction. When received from a WV network provider, coverage is at 80 percent after the in-network deductible is met. Voluntary preapproval is recommended for orthognathic procedures and ridge reconstruction procedures to assure that the procedure will be eligible for coverage. Dental implants are not covered.
Organ Transplants	See "Organ Transplant Benefits" for details.
Outpatient Diagnostic and Therapeutic Services	Laboratory, diagnostic tests, and therapeutic treatments, when ordered by a physician, are covered at 80% after the in-network deductible is met.
Outpatient Surgery	This benefit is subject to a $50 copayment and 20% coinsurance in-network when performed in a hospital or alternative facility.
Outpatient Therapies	Coverage for the following outpatient therapies are combined into one benefit and are available at 80% after the in-network deductible is met: physical, massage, occupational, speech, and vision therapies, osteopathic manipulations and chiropractic treatment. The benefit is limited to a maximum of 20 visits per person per plan year for all of the therapies combined. Case management is required for more than 20 visits. Initial 20 visits require a $10 copayment per visit. Visits 21 +, if approved by ActiveHealth, require a $25 copayment per visit. • **Chiropractic Treatment** Services of a chiropractor for acute treatment of neuromuscular-skeletal conditions are included in the Outpatient Therapies benefit (see above) and are covered at 80% after the in-network deductible and $10 or $25 copayment (details above) are met. Office visits are subject to a copayment and x-rays are covered at 80% after deductible is met. Maintenance services are not covered. Preauthorization is recommended for services for children under age 16. • **Massage Therapy**. When ordered by a physician, therapeutic massage therapy services of a licensed massage therapist are covered at 80% after the in-network deductible and $10 or $25 copayment (details above) are met. • **Occupational Therapy**. When ordered by a physician, this benefit is included in the

	Outpatient Therapies benefit and is covered at 80% after the in-network deductible and $10 or $25 copayment (details above) are met. • **Osteopathic Manipulations**. Services of an osteopathic physician to eliminate or alleviate somatic Dysfunction and related disorders are covered at 80% after the in-network deductible and $10 or $25 copayment (details above) are met. . • **Outpatient Physical Therapy**. When ordered by a physician, this benefit is included in the Outpatient Therapies benefit and is covered at 80% after the in-network deductible and $10 or $25 copayment (details above) are met. • **Outpatient Speech Therapy**. When ordered by a physician, this benefit is included in the Outpatient Therapies benefit and is covered at 80% after the in-network deductible and $10 or $25 copayment (details above) are met. • **Vision Therapy**. Contact ActiveHealth for preauthorization of these services. This benefit is included in the Outpatient Therapies benefit and is covered at 80% after the in-network deductible and $10 or $25 copayment (details above) are met.
Pain Management Services	Covered at 80% after the in-network deductible is met.
Pap Smear	An annual Pap smear and the associated office visit to screen for cervical abnormalities are covered. The screening is covered in full if conducted as a part of the Routine Physical and Screening Exam, or with a $10 preventive care office visit copayment, if not. When billed with a medical diagnosis (instead of as a screening test), it is considered a diagnostic test, and the deductible and 20% coinsurance will apply.
Physician Office Visits (Preventive Care)	With WV network providers, some visits are subject to a $10 copay not subject to the deductible. When there are no illness present, office visits for the following covered services are considered "Preventive Care": colorectal cancer screening, hypertension screening, immunizations for persons ages 17 and over, kidney disease screening, screening mammograms, annual Pap smears, prostate cancer screening, and routine periodic physical exams (adults).
Physician Office Visits (Treatment for Illness, of Injury or Medical Condition)	With WV network providers, these visits require a $15 copay and are not subject to the deductible. Professional Services of a Physician or Other Licensed Provider for Treatment Injury, or Medical Illness, includes outpatient and inpatient services (such as Condition surgery, anesthesia, radiology, and office visits). With WV network providers, office visits for specialty care a $25 copay . Other services from WV network providers are covered at 80 percent after the in-network deductible is met.
Prostate Cancer Screening	Coverage is provided for an annual office visit and exam to detect prostate cancer in men ages 50 and over. With WV network providers, the PSA blood test associated with this screening is covered at 100 percent with no deductible or coinsurance. The associated office visit is subject to a $10 "Preventive Care" office visit copay.
Routine Physical and Screening Examinations	AccessWV covers a routine physical exam once every two years for adults ages 18 and over. Exams may be provided more often if the patient's medical history indicates a need. With WV network providers, routine physicals are subject to the $10 "Preventive Care" office visit copay. This office visit generally includes but is not limited to: • height and weight measurement • blood pressure check • health risk and prevention counseling, and • physical examination Diagnostic testing, lab and x-rays, provided in conjunction with a periodic physical are covered, if medically necessary, and billed with a medical diagnosis. With WV network providers, these services are covered at 80 percent after the in-network deductible. Only the screenings specifically listed in this "What is Covered" section will be covered as routine screenings.

Second Surgical Opinions	Office visits with WV network providers for second surgical opinions are subject to a $15 copay per visit with no deductible. If required by ActiveHealth, second surgical opinions from WV network providers are covered in full; no copay is required.
SPECT	Single photon emission computer tomography is covered at 80% after the in-network deductible is met. All visits are subject to copayments and/or deductibles.
Skilled Nursing Facility Services	Confinement in a network skilled nursing facility in WV including semi-private room, related services and supplies, is covered at 80% after the in-network deductible is met. Confinement must be prescribed by a physician in lieu of hospitalization. Coverage is limited to 100 days per member per plan year.
Tobacco Cessation Program	AccessWV provides benefits for members who wish to quit smoking or who wish to stop using smokeless tobacco products. The tobacco cessation benefit is available to all members regardless of whether they are meeting a waiting period for pre-existing conditions. AccessWV will cover an office visit if it is required to obtain a prescription for tobacco cessation drugs. This visit is not subject to the medical deductible. AccessWV will pay for prescription and non-prescription tobacco cessation products, if they are dispensed with a prescription, as part of its pharmacy benefit. Nicotine patches are available at no cost to the member. Both the deductible and the copayment are waived on nicotine patches when prescribed by a physician and purchased at a network pharmacy. Otherwise, coverage is subject to the drug deductible. With the exception of nicotine patches, all prescription and over-the-counter (OTC) tobacco cessation products will be covered with the applicable generic ($5), preferred ($15) or non-preferred ($50) copayment, depending on their status on the Preferred Drug List. For pregnant members (policyholder and spouses only), AccessWV will provide 100 percent coverage for tobacco cessation products with no deductible or copayment. Coverage for a tobacco cessation product is limited to one 12-week cycle per rolling 12-month period. There is a lifetime benefit limit of 3 cycles. Members taking tobacco cessation products are encouraged to enroll in the hotline maintained by the pharmaceutical company making their drug to obtain support and counseling for their quit-smoking effort. The tobacco cessation benefit is summarized below.

Weight Management Program	PEIA offers a facility-based weight management program for AccessWV members who have a Body Mass Index (BMI) of 25 or greater or a waist circumference of 35 inches or greater for women or 40 inches or greater for men. The program includes comprehensive services from registered and licensed dietitians, degreed exercise physiologists and personal trainers at approved fitness centers. The current list of participating facilities is on PEIA's website at www.wvpeia.com. This is a once per lifetime benefit that may last up to two years and has a copayment of **$20** per month. To enroll, you must complete the application, which includes some medical information, and provide written approval from your physician. For more information or to enroll in the program, call 1-866-688-7493 or go to www.wvpeia.com.
Well Child Care	For children through age 16, AccessWV covers routine office visits for preventive care as recommended by the American Academy of Pediatrics. These visits are covered at 100 percent of allowed charges and are not subject to copays, coinsurance or the deductible. This office visit generally includes, but is not limited to: • height and weight measurement, • blood pressure check, • vision and hearing screening, • developmental/behavioral assessment, and • physical examination. • "Well Child Care" office visits are recommended by the American Academy of Pediatrics at the following ages: • Infancy: 1 month, 2 months, 4 months, 6 months, 9 months and 12 months. • Early childhood: 15 months, 18 months, 24 months, 30 months, 3 years and • 4 years. • Late childhood: Annually from ages 5 through 12. • Adolescence: 13 years, 14 years, 15 years and 16 years. There is a $10 copayment for routine preventive care office visits for adolescents over the age of 16 with WV network providers. No deductible applies.

SPECIAL BENEFITS

MATERNITY CARE

AccessWV provides coverage for maternity-related professional and facility services, including prenatal care, midwife services and birthing centers. Maternity-related services are covered only for the policyholder or the policyholder's enrolled spouse. Contact **ActiveHealth at 1-866-864-6142** during the first trimester of your pregnancy or as soon as your pregnancy is confirmed. You will need to contact ActiveHealth anytime you are admitted to the hospital during your pregnancy and within 48 hours of your admission for delivery, even if you are discharged in less than 48 hours.

When received from WV network providers, maternity services for routine prenatal care, delivery and follow-up are paid at 100 percent of allowed charges under a global fee after the in-network deductible has been met. An obstetrical profile and one ultrasound are also paid at 100 percent of allowed charges after the deductible is met. Other maternity services, including hospital charges and anesthesia services, are paid at the regular AccessWV level of 80 percent of allowed charges after the in-network deductible is met.

Prior approval is required for maternity services received outside of West Virginia. If prior approval is granted, payment is at the out-of-state benefit rate and varies depending upon whether the provider is in-network or out-

of- network. Please see your Summary of Benefits. Benefits for maternity services received out-of-state without prior approval are subject to a penalty. See "Benefits for Services Received Outside of West Virginia."

If your WV network provider requests a deposit for maternity care before delivery, AccessWV will make an advance payment of up to $500. This will be deducted from the global fee paid after delivery. To receive this benefit, please contact HealthSmart and request a Maternity Pre-payment form.

HIGH RISK BIRTH SCORE PROGRAM

For infants identified at birth as being at risk for health problems, AccessWV will pay for six office visits between the age of two weeks and 24 months in addition to AccessWV's regular Well Child Care benefits. The additional visits are paid at 100 percent of allowed charges and are not subject to the deductible.

ENROLLING YOUR NEWBORN

Please be sure you remember to add your newborn to your coverage by completing a "Change of Status" Form. Request a "Change of Status" Form by calling the Plan Administrator HealthSmart at 1-866-864-6142. See the "Eligibility & Membership" section for more information.

NURSERY CHARGES

If the baby is enrolled for coverage under AccessWV, charges for the newborn nursery care will be paid in the baby's name. If the baby is not enrolled for coverage under AccessWV, charges for a normal, healthy newborn's nursery care will be covered as part of the mother's maternity benefit.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

AccessWV's maternity benefit meets or exceeds all of the requirements of the Newborns' and Mothers' Health Protection Act. Under federal law, health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by Caesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, Plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a Plan or issuer may not, under federal law, require that a physician or other health care provider obtain approval for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior approval. For information on prior approval, contact **ActiveHealth at 1-866-864-6142 (toll-free)**.

ORGAN TRANSPLANT BENEFITS

Organ transplants are covered when deemed medically necessary and non-experimental. They are subject to precertification and case management by **ActiveHealth**. You should contact ActiveHealth as soon as you learn that you or a member of your family may need a transplant.

All transplants require precertification for determination of medical necessity. When it is determined by your physician that you are a potential candidate for any type of transplant, **ActiveHealth** should be contacted immediately. They will identify Institutes of Excellence with experience in the specific type of transplant you require. You should advise your physician that **ActiveHealth** needs to coordinate the care from the initial phase

when considering a transplant procedure, initial workup for transplant through the performance of the procedure and the care following the actual transplant.

Any services and supplies that are required for donor/procurement as a result of a surgical transplant procedure for a participant will be covered. Benefits for such charges, services and supplies are not provided under the AccessWV Plan if benefits are provided under another group plan or any group or individual contract or any arrangement of coverage for individuals in a group (whether on an insured or uninsured basis), including any prepayment coverage. Testing for persons other than the chosen donor is not covered.

The AccessWV Plan uses network providers for organ transplant services. This helps to control health care costs for both you and the plan. AccessWV uses Aetna's Institutes of Excellence for its transplant network. ActiveHealth will work with patients and physicians to determine which network facility best serves the patient's medical needs.

Once the annual deductible and out-of-pocket maximum have been met, you will pay no more coinsurance on the negotiated fees for pre-transplant, transplant, and follow-up services.

Travel Allowance
Because network facilities may be located some distance from the patient's home, benefits include up to $5,000 per transplant for patient travel, lodging and meals. A portion of this benefit is available to cover the travel, lodging and meals for a member of the patient's family or a friend providing support. Receipts are required for payment; mileage and cost estimates are not acceptable.

Medical Case Management
ActiveHealth offers support and assistance in evaluating treatment options and referrals to the prescription drug administrator. Management begins early when the potential need for a transplant is identified, and continues through the surgery and follow-up. You should contact ActiveHealth as soon as you learn that you or a member of your family covered by AccessWV may need a transplant. All transplants must be pre-certified through ActiveHealth.

Out-Of-Network Organ Transplant Benefits
For patients who choose to use a non-network facility for transplant services, there will be a $10,000 deductible applied to the cost of the hospital admission; this is in addition to your annual deductible and out-of-pocket maximum. This deductible will be waived only if treatment at a non-network facility is approved as medically necessary in advance by ActiveHealth. No travel benefits will be provided for out-of-network transplants (except medically necessary ambulance transport).

Transplant-Related Prescription Drugs
AccessWV covers transplant-related immunosuppressant prescription drugs at 100 percent, after you have met your prescription drug deductible (if they are filled at a network pharmacy). These are covered through the Prescription Drug Plan and processed by the prescription drug administrator. Details of the AccessWV Drug Plan are found in the "Prescription Drug Benefits" section.

Medical case management of transplant patients includes referral to the prescription drug administrator for waiver of copayments on transplant-related immunosuppressant drugs. ActiveHealth will make arrangements with the prescription drug administrator to waive copayments on drugs used to sustain the transplant.

OUT-OF-STATE SERVICES WITH NETWORK PROVIDERS

In general, services received out-of-state require higher member cost-sharing than services received from WV network providers. For the full out-of-state benefit to apply, these services must receive prior approval. If you do not receive prior approval, out-of-state services will be covered at a lower rate.

In general, the member's share of costs is 30 percent when services are received from out-of-state network providers and prior approval has been obtained. Services that are covered in full or that require only a copayment when received from West Virginia network providers require 30 percent coinsurance when received from out-of-state network providers with prior approval. The exception is well child care, which is covered in full. Please see your **Summary of Benefits**.

The in-network deductible applies to these out-of-state services. This means AccessWV's share of costs is 70 percent, after the member meets the in-network deductible. Some services require a copayment in addition to the coinsurance. See below for highlights of the benefit differences when services are received from WV network providers and when they are received from out-of-state network providers with prior approval.

Service	WV Network Providers	Out-of-State Network Providers (with Prior Approval)
Office visits –primary care Office visits- specialty care	$15 $25	30% coinsurance* 30% coinsurance
Routine physicals	$10	30% coinsurance*
Preventive services (mammograms, Pap smears, etc.)	$0, covered in full	30% coinsurance*
Prenatal care	$0*	30% coinsurance*
All services with coinsurance	20% coinsurance*	30% coinsurance*
Ambulatory/outpatient surgery	$50 copay + 20% coinsurance*	$75 copay + 30% coinsurance*

* In-network deductible applies.

Without prior approval, the member's coinsurance for services received from out-of-state network providers will increase to 50 percent. An additional penalty of $1,000 will apply to all hospital stays. Emergency care is not required to have prior approval.

SERVICES FROM OUT-OF-NETWORK PROVIDERS

In general, the members' share of cost is 40 percent when services are received from out-of-network providers and prior approval has been obtained from ActiveHealth. Services that are covered in full or that require only a copayment when received from West Virginia network providers require 40 percent coinsurance when received from out-of-state network providers with prior approval. The exception is well child care, which is covered in full. Please see your **Summary of Benefits.**

The out-of-network deductible applies to these out-of-network services. This means AccessWV's share of costs is 60 percent, after the member meets the out-of-network deductible.

In addition to the 40 percent coinsurance, the following inpatient services require a $500 copay after the out-of-network deductible is met: inpatient hospital care, maternity care (delivery), rehabilitation facility, skilled nursing facility, inpatient mental health & chemical dependency services and inpatient detoxification. The copayment for ambulatory/outpatient surgery is $100 when this service is received from an out-of-network provider. See below for highlights of the benefit differences when services are received from WV network providers and when they are received out-of-network with prior approval.

Service	WV Network Providers	Out-of-State Network Providers (with Prior Approval)
Office visits –primary care Office visits- specialty care	$15 $25	40% coinsurance* 40% coinsurance*
Routine physicals	$10	40% coinsurance*
Preventive services (mammograms, Pap smears, etc.)	$0, covered in full	40% coinsurance*
Prenatal care	$0*	40% coinsurance*
All services with coinsurance	20% coinsurance*	40% coinsurance**
Inpatient services	20% coinsurance*	$500 copay + 40% coinsurance**
Ambulatory/outpatient surgery	$50 copay + 20% coinsurance*	$100 copay + 40% coinsurance**

* after the in-network deductible
** after the out-of-network deductible

Without prior approval, there is no change to the cost sharing level. However, AccessWV changes the basis for its payment from the "reasonable and customary" amount to the PEIA reimbursement schedule. This leaves the member open to balance billing for the charges above AccessWV's allowed amount.

SPECIAL PROGRAMS HEALTHY TOMORROWS

AccessWV has implemented a program called Healthy Tomorrows that coordinates all of AccessWV's continuing lifestyle management programs under one umbrella. The programs included in Healthy Tomorrows are:

Dr. Dean Ornish Program for Reversing Heart Disease

The Dr. Dean Ornish Program for Reversing Heart Disease is an intensive program for patients who meet the medical criteria for participation: coronary artery disease, Type I or Type II diabetes, or at high risk for these conditions.
The Ornish approach does not use drugs or surgery, but relies upon nutrition, physical activity, group support and stress management as part of an intensive lifestyle change program. Applicants are screened by their local participating Ornish hospital to determine if they meet the medical criteria for participation listed above.
For members of AccessWV, the program is covered at 100% after a participant copayment of $50 per month, which is refundable after the successful completion of the program. Participants with annual household income below $20,000 per year may qualify for a copayment waiver.

For more information about this program, visit PEIA's "Health and Wellness Programs" link on our website or contact PEIA's customer service unit at 1-888-680-7342.

This program is a once-in-a-lifetime enrollment.

Dean Ornish Spectrum

Dean Ornish Spectrum is a six week lifestyle education program based upon the principles of Dr. Dean Ornish as described in his book of the same title. This benefit is covered with a $48 copay and no deductible or coinsurance for members of AccessWV. This once-in-a-lifetime benefit is available to members who meet any one of the following criteria:

1. Family or personal history of coronary artery disease, hypertension and/or diabetes;
2. Aged 50 or older
3. BMI>25
4. Metabolic syndrome
5. Family or personal history of cancer.

For more information, visit the "Health and Wellness Programs" link on PEIA's website at www.wvpeia.com for a complete listing of participating hospitals and contact PEIA's customer service unit at 1-888-680-7342.
(This program is an alternative to the Ornish Program and is a once-in-a-lifetime benefit. You can only attend one program so it is an either/or type of benefit.)

Face-to-Face (F2F) Diabetes Program

PEIA's F2F Diabetes Program for AccessWV members is available statewide (subject to the availability of pharmacists) for those who have diabetes.
Under the program, members and/or their dependents with diabetes or gestational diabetes agree to make regular visits to a participating pharmacist of their choosing for counseling and health education services. The pharmacist works with each member to ensure he/she gets the best diabetes care possible by monitoring:

- recommended testing and treatment of diabetes;
- the member's currently prescribed medicines and knowledge about how to take them; and
- physical activity and nutrition plan to assist the member in achieving optimal health.

Members benefit from participating in the F2F Diabetes program by improving their health and quality of life. Also AccessWV members benefit by saving money, since copayments are waived for some prescription drugs, lab tests and/or supplies. AccessWV benefits from the member's better management of their disease through fewer health care costs from the disease or its complications.

Members participating in the F2F Diabetes program must be tobacco free for a minimum of six months prior to enrollment in the program. F2F is a once-in-a-lifetime benefit (with the exception of gestational diabetes). Prior participation in the Dr. Dean Ornish Program for Reversing Heart Disease or prior bariatric surgery will make the member ineligible to participate in F2F.
For more information or an application, visit www.peiaf2f.com, or call PEIA Customer Service at 1-888-680-7342.

Hemophilia Disease Management Program

To provide quality care at a reasonable cost, PEIA and the Charleston Area Medical Center (CAMC) have partnered to provide a Hemophilia Care Program to PEIA PPB Plan members. Under the program, members and/or their dependents with hemophilia agree to receive an annual evaluation from the Hemophilia Treatment Center at CAMC. Members who participate in the program will be eligible for the following benefits:

1. An annual evaluation by specialists in the Hemophilia Treatment Center at CAMC will be paid at 100% with no deductible, copay or coinsurance. (This evaluation is not intended to replace or interrupt care provided by your existing medical home provider or specialists.)
2. Hemophilia expenses, including factor replacement products, incurred at CAMC will be paid at 100% with no deductible, copay or coinsurance.
3. Reimbursement for travel and lodging
    a. Child and 1 or 2 parents
    b. Adult and an accompanying adult
    c. Lodging will be at the CAMC travel lodge for a maximum of two (2) nights.
    d. Gas will be reimbursed at the state rates.
    e. Receipts for food will be paid at 100% for the child and parents or for the 2 adults.

Lodging And Travel Expenses:
Lodging expenses include:

1. Expenses incurred by the patient traveling between his or her home and CAMC to receive services in connection with the PEIA/CAMC Hemophilia Disease Management Program.
2. Expenses incurred by the patient's companion to enable the patient to receive services from the PEIA/CAMC hemophilia Disease Management Program.

a. For children under the age of 18, lodging will be covered for one (1) or two (2) parents.
b. For patients over the age of 18, lodging will be covered for one (1) companion.

3. Lodging will be covered at 100% of the charge at CAMC's travel lodge in Kanawha City. Other hotel/motel expenses will be covered, not to exceed the cost at CAMC's travel lodge. The current rate is $57.12 per night.

Travel expenses (gas & meals) include:

1. Expenses incurred while traveling with the patient between the patient's home and the medical facility to receive services in connections with the PEIA/CAMC Hemophilia Disease Management Program.
2. Gas receipts are required for reimbursement.
3. Receipts are required for the reimbursement of meals.
   a. The daily limit per individual is $30 per person.

All claims must be submitted within the six-month timely filing period, including the submission of all lodging and travel expenses. For more information about this program please contact: CAMC Hemophilia Treatment Center at 304-388-8896 or ActiveHealth at 888-440-7342

Sleep Management Services

AccessWV covers service for the treatment of sleep apnea and other related conditions that can affect your health. In order to ensure compliance and ensure responsible use of all prescribed sleep services, HealthSmart, the third-party administrator for PEIA, has contracted with Sleep Management Solutions (SMS) to manage the PEIA's sleep services for resident PPB Plan members. All sleep-testing services require prior approval. A precertification process has been established to ensure that the services are medically necessary and appropriate. If your physician says you need a sleep test, ask him/her to call SMS at 1-888-49-SLEEP (1-888-497-5337). If approved, you will be provided a list of contracted labs that you may use to receive services.

In addition to managing sleep-testing services, SMS is the sole source for CPAP and Bi-Level equipment and supplies. The process is integrated so that patients who have been diagnosed and prescribed CPAP or Bi-level therapy are set up and educated at the lab where they received their sleep study.

Sleep Management Solutions has a 24-hour hotline that AccessWV members may access to get information on their sleep illness and how best to use their sleep equipment. A Respiratory Therapist or a trained sleep technician is available to provide support when issues come up, which is generally at bedtime. You may also visit the PEIA Sleep website at www.wvpeiasleep.com. (AccessWV follows these guidelines.)

SMS will contact you regularly to make sure there are no issues which might be impeding compliance. If you have problems with masks or equipment, call SMS for assistance. Patient care and improved health is the most important aspect of this process.

Tobacco Cessation Program

A Tobacco Cessation Program is available to AccessWV members who want to stop smoking or using smokeless tobacco products, regardless of the member's pre-existing condition status.

AccessWV covers an initial and follow-up visit with a physician or nurse practitioner, for which copayment applies, but visits are not subject to the medical deductible. Policyholders and policyholder spouses who are pregnant receive 100% coverage with no copayments or deductible.

Both prescription and non-prescription tobacco cessation medications are covered when dispensed with a prescription, subject to the pharmacy benefit deductible. Prescribed nicotine patches are available at no cost to the member, and both deductible and copay are waived when purchased at a WV network pharmacy. Other

prescription and over-the-counter (OTC) tobacco cessation drugs and products are covered with the applicable generic ($5), preferred ($15), or non-preferred (75%) copayment, depending on their status on the Preferred Drug List. Coverage of tobacco cessation drugs and products is limited to one 12-week cycle per rolling 12-month period. There is a lifetime benefit maximum of three cycles. The tobacco cessation benefit is summarized in the following chart:

Smoking Cessation Benefit	**Cost to Member**
Prescription & non-prescription tobacco cessation products (when dispensed with a prescription) (*except nicotine patches*)	Drug deductible applies. After, deductible, copay of $5, $15 or 75% depending on drug selected. Deductible and copays waived for pregnant policyholders and spouses.
Nicotine patches	$0, covered in full.
Office visit to obtain prescription for smoking cessation drug	$10 copayment, medical deductible does not apply.

WHAT IS NOT COVERED

Some services are not covered by AccessWV regardless of medical necessity. Specific exclusions are listed below. If you have questions, please contact HealthSmart at 1-866-864-6142(toll-free). The following services are NOT covered:

1. Acupuncture
2. Aqua therapy.
3. Autopsy and other services performed after death, including transportation of the body or repatriation of remains.
4. Biofeedback.
5. Birth control drugs, devices, and services for dependent children.
6. Breast pumps.
7. Chemical dependency treatments when a patient leaves the hospital or facility against medical advice.
8. Coma stimulation.
9. Cosmetic or reconstructive surgery when not required as the result of accidental injury or disease, or not performed to correct birth defects. Services resulting from or related to these excluded services also are not covered.
10. Custodial care, intermediate care (such as residential treatment centers), domiciliary care, respite care, rest cures, or other services primarily to assist in the activities of daily living, or for behavioral modification, including applied behavior analysis (ABA), except to the extent ABA is mandated to be covered for treatment of autism spectrum disorder by W. Va. Code §5-16-7(a)(8).
11. Dental implants, whether medically indicated or not.
12. Dental services including dental implants, routine dental care, x-rays, treatment of cysts or abscesses associated with the teeth, dentures, bridges, or any other dentistry and dental procedures.
13. Daily living skills training.
14. Duplicate testing, interpretation or handling fees.
15. Education, training and/or cognitive services, unless specifically listed as covered services.
16. Elective abortions.
17. Electronically controlled thermal therapy.
18. Emergency evacuation from a foreign country, even if medically necessary.
19. Expenses for which the patient is not responsible, such as patient discounts and contractual discounts.
20. Expenses incurred as a result of illegal action, while incarcerated or while under the control of the court system;

21. Experimental, investigational or unproven services, unless pre-approved by ActiveHealth.
22. Fertility drugs and services.
23. Foot care. Routine foot care including:
    - Removal in whole or in part of: corns, calluses (thickening of the skin due to friction, pressure, or other irritation), hyperplasia (overgrowth of the skin), or hypertrophy (growth of tissue under the skin);
    - Cutting, trimming, or partial removal of toenails;
    - Treatment of flat feet, fallen arches, or weak feet; and
    - Strapping or taping of the feet.
24. Genetic testing for screening purposes is generally not covered. See Precertification on page 35 for exceptions.
25. Glucose monitoring devices, except Bayer Ascensia models covered under the prescription drug benefit.
26. Homeopathic medicine.
27. Hospital days associated with non-emergency weekend admissions or other unauthorized hospital days prior to scheduled surgery.
28. Hypnosis.
29. Incidental surgery performed during medically necessary surgery.
30. Infertility and sterility services of in vitro fertilization and gamete intrafallopian transfer (GIFT), embryo transport, surrogate parenting, and donor semen, any other method of artificial insemination, and any other related services.
31. Maintenance outpatient therapy services, including, but not limited to:
    -
    - Chiropractic
    - Massage Therapy
    - Occupational Therapy
    - Osteopathic Manipulations
    - Outpatient Physical Therapy
    - Outpatient Speech Therapy
    - Vision Therapy

32. Marriage counseling.
33. Medical equipment, appliances or supplies of the following types:
    - augmentative communication devices.
    - bathroom scales.
    - educational equipment.
    - environmental control equipment such as air conditioners, humidifiers or dehumidifiers, air cleaners or filters, portable heaters, or dust extractors.
    - equipment or supplies which are primarily for patient comfort or convenience, such as bathtub lifts or seats; massage devices; elevators; stair lifts; escalators; hydraulic van or car lifts; orthopedic mattresses; walking canes with seats; trapeze bars; child strollers; lift chairs(including Hoyer lifts); recliners; contour chairs; adjustable beds; or tilt stands.
    - equipment which is widely available over the counter such as wrist stabilizers and knee supports.
    - exercise equipment such as exercycles; parallel bars; walking, climbing or skiing machines.
    - hearing aids of any type.

- hygienic equipment such as bed baths, commodes, and toilet seats.
- motorized scooters.
- nutritional supplements, over-the-counter (OTC) formula, food liquidizers or food processors.
- Omnipod, V-go, Finesse and other disposable insulin delivery systems.
- orthopedic shoes, unless attached to a brace.
- professional medical equipment such as blood pressure kits or stethoscopes.
- replacement of lost or stolen items.
- supplies such as tape, alcohol, Q-tips/swabs, gauze, bandages, thermometers, aspirin, diapers (adult or infant), heating pads or ice bags.
- traction devices.
- vibrators.
- whirlpool pumps or equipment.
- wigs or wig styling.

34. Medical rehabilitation and any other services that are primarily educational or cognitive in nature.
35. Mental health or chemical dependency services to treat mental illnesses which will not substantially improve beyond the patient's current level of functioning.
36. Optical services.
    - Routine eye examinations, refractions, eye glasses, contact lenses and fittings.
    - Glasses and/ or contact lenses following cataract surgery.
    - Low vision devices, including magnifiers, telescopic lenses and closed circuit television systems
37. Oral appliances, including, but not limited to, those treating sleep apnea.
38. Orientation therapy.
39. Orthodontia services.
40. Orthotripsy.
41. Physical examinations and routine office visits except those covered under the Periodic Physicals benefit.
42. Personal comfort and convenience items or services (whether on an inpatient or outpatient basis) such as television, telephone, barber or beauty service, guest services, and similar incidental services and supplies, even when prescribed by a physician.
43. Physical conditioning and work hardening. Expenses related to physical conditioning programs and work hardening such as athletic training, body building, exercise, fitness, flexibility, diversion, or general motivation.
44. Physical, psychiatric, or psychological examinations, testing, or treatments not otherwise covered under the plan, when such services are:
    - conducted for purposes of medical research;
    - for participation in athletics;
    - needed for marriage or adoption proceedings;
    - related to employment;
    - related to judicial or administrative proceedings or orders;
    - to obtain or maintain a license or official document of any type; or
    - to obtain or maintain insurance.
45. Pregnancy-related conditions for dependent children.
46. Provider charges for phone calls, prescription refills, or physician-to-patient phone consultations.
47. Radial keratotomy and other surgery to correct vision.
48. Reversal of sterilization and associated services and expenses.

49. Safety devices. Devices used specifically for safety or to affect performance primarily in sports-related activities.
50. Screenings, except those specifically listed as covered benefits.
51. Services rendered by a provider with the same legal residence as a participant, or who is a member of the policyholder's family. This includes spouse, brother, sister, parent, or child.
52. Services rendered outside the scope of a provider's license.
53. Sex transformation operations and associated services and expenses.
54. Skilled nursing services provided in the home, except intermittent visits covered under the Home Health Care benefit.
55. Stimulation therapy.
56. Take-home drugs provided at discharge from a hospital.
57. TMJ. Treatment of temporomandibular joint (TMJ) disorders. Including intraoral prosthetic devices or any other method of treatment to alter vertical dimension or for temporomandibular joint dysfunction not caused by documented organic disease or acute physical trauma.
58. The difference between private and semi-private room charges.
59. Therapy and related services for a patient showing no progress.
60. Therapies rendered outside the United States that are not medically recognized within the United States.
61. Transportation other than medically necessary emergency ambulance services, or as approved under the Organ Transplant Network benefit.
62. War-related injuries or illnesses. Treatment in a State or Federal hospital for military or service-related injuries or disabilities.
63. Weight loss. Health services and associated expenses intended primarily for the treatment of obesity and morbid obesity, including wiring of the jaw, weight control programs, weight control drugs, screening for weight control programs, and services of a similar nature, except those services provided through the program offered by PEIA.
64. Work-related injury or illness.

PRESCRIPTION DRUG BENEFITS

Along with your medical coverage, you also have prescription drug coverage. Your prescription drug benefits pay for a wide range of medications, with differing copayments depending on where they are purchased and how large a supply you buy. The prescription drug program is administered by Express Scripts, Inc.. There are three parts to the program:

- The Retail Pharmacy Program gives you access to local participating pharmacies to get your prescriptions filled.
- The Express Scripts Mail Service Pharmacy Program lets you order your prescriptions through the mail, saving you time and money by having your maintenance medications delivered to your door.
- The HealthSmart Specialty Medication Program provides your common specialty medications through the mail, saving you time by having your medications delivered to your door or to your physician's office.

PRESCRIPTION DRUG DEDUCTIBLE

Each plan year, you must meet a deductible amount before AccessWV begins to pay for covered prescription drugs. The deductible amount depends on the Plan chosen, and is shown in the table below.

The family deductible is twice the individual deductible. The family deductible is divided up among the family members. No one member of the family will pay more than the individual deductible. Once that person has met the individual deductible, the Plan will begin paying on that person. When another member of the family meets the individual deductible, then the Plan will begin paying on the entire family. Alternatively, all members of the family may contribute to the family deductible with no one person meeting the individual deductible. Once the family deductible is met, the Plan pays on all members of the family. After the deductible is met, you will pay copayments based on the amount and type of drug you are taking.

PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM

The prescription Drug Benefit has out-of-pocket maximums of $2,000 for an individual and $4,000 for a family, separate from Medical out-of-pocket maximums. The out-of-pocket maximum includes copayments at an in-network pharmacy for generic and listed brand-name drugs on the WV Preferred Drug List, not deductible amounts or other charges. Once you have met the drug out-of-pocket maximum, the entire cost of the prescription drugs is covered for the remainder of the Plan Year until you reach the drug benefit maximum of $50,000 per member per Plan Year or the Plan Benefit Maximum of $1 million per year. You will continue to incur costs if you use an out-of-network pharmacy or an unlisted brand-name drug not listed on the WV Preferred Drug List.

Prescription Drug		Plan A	Plan B	Plan C	Plan D
Annual Deductible	Individual Family	$200 $400	$400 $800	$1,000 $2,000	$2,000 $4,000
Annual Out-of-Pocket Maximum	Individual Family	$2,000 $4,000	$2,000 $4,000	$2,000 $4,000	$2,000 $4,000

PRESCRIPTION DRUG COPAYMENTS

Under your prescription drug Plan, once you meet your deductible, you pay a copayment to obtain drugs. Copayments are the portion of the cost that, under your Plan, you are required to pay for new or refill prescriptions until your drug out-of- pocket maximum is met. The rest of the cost is paid by AccessWV. Several factors determine your copayment.

GENERIC DRUGS

The brand name of a drug is the product name under which the drug is advertised and sold. Generic medications have the same active ingredients and are subject to the same rigid U.S. Food and Drug Administration (FDA) standards for quality, strength and purity as their brand-name counterparts. Generic drugs usually cost less than brand-name drugs. Please ask your doctor to prescribe generic drugs whenever possible. You will have the lowest copayments with generic drugs.

WEST VIRGINIA PREFERRED DRUG LIST (WVPDL) (“FORMULARY”)

The West Virginia Preferred Drug List (WVPDL) or the “Formulary” is a list of carefully selected medications that can assist in maintaining quality care while providing opportunities for cost savings to AccessWV. Under this program, AccessWV requires you to pay a lower copayment for medications on the WVPDL and a higher copayment for medications not on the WVPDL. By asking your doctor to prescribe WVPDL medications, you can maintain high-quality care while you help to control rising health care costs. The formulary may change at any time during the plan year.

Here’s how the copay structure works:

- **Highest Copay:** You will pay the highest copay for brand-name drugs that are not listed on the WVPDL.
- **Middle Copay:** You will pay mid-level copay for brand-name drugs that are listed on the WVPDL.
- **Lowest Copay:** You will pay the lowest copay for all generic drugs.

Sometimes your doctor may prescribe a medication to be "dispensed as written" when a WVPDL brand name or generic alternative drug is available. As part of your AccessWV coverage, an Express Scripts pharmacist or your retail pharmacist may discuss with your doctor whether an alternative formulary or generic drug might be appropriate for you. Your doctor always makes the final decision on your medication, and you can always choose to keep the original prescription at the higher copayment.

Drugs on the WVPDL are determined by the Express Scripts Pharmacy and Therapeutics Committee. The committee, made up of physicians, meets quarterly to review the medications currently on the Formulary, and to evaluate new drugs for addition to the Formulary. The Formulary may change periodically, based on the recommendations adopted by the committee. If you have any questions about the copay structure or about the Formulary, please call Express Scripts Member Services at 1-877-256-4680.

Prescription Drug Copayments (After Deductible)		
	In-Network*	**Maintenance****
	Up to 30 day supply	**90 day supply**
Generic drug	$5	$10
Brand name drug listed on WV Preferred Drug List	$15	$30
Unlisted brand-name Drug WV Preferred Drug List	75% coinsurance	75% coinsurance
Common Specialty Medications***	$50	NA

* Out of network pharmacy: Plus $3

Maintenance Drugs are certain generic and Preferred Brand drugs prescribed on a long-term basis and are eligible for reduced copayments on a 90-day supply. The following Maintenance Drugs ONLY may be purchased in a 90-day supply for two months' copayment from pharmacies in the WV PEIA Retail Maintenance Network or via the Express Scripts mail service pharmacy.

Maintenance Drugs	
Alendronate sodium (Fosamax®)	Estrogens and progestins
Antiarthritics	Gastronintestina, colitis
Anticoagulants	Glaucoma agents
Anticonfulsants	Gout medications
Antidementia drugs	Hormones, misc.
Antihypertensives	Immunosuppressive agents
Antiparkinsonism agents	Legend vitamins (including legend hematinics, vitamin K)
Antispasmodics: urinary tract	Leukotriene receptor antagonists (asthma agents)
Benign prostatic hypertrophy/micturition	Lipotropics (cholesterol lowering agents)
Bronchodilators	Mucolytics (pulmonary agents)
Calcitonin (Miacalcin®)	Oral contraceptives
Cardiovascular agents	Legend potassium
Cholinergic stimulants (urinary retention)	Raloxifene (Evista)
Corticosteroids, bronchial	Risedronate (Actonel)
Cromolyn sodium (Intal®)	Selective serotonin reuptake inhibitors
Diabetic therapies	Serotonin and norepinephrine reuptake inhibitors
Digestants	Thyroid medications
Disposable needles and syringes	Tuberculosis medications
Diuretics	Xanthines (asthma agents)
Enzymes, systemic	

Maintenance Drug Copayments Via Retail Maintenance Network or Mail Service Pharmacy		
	Up to 30 day supply	**90 day supply**
Generic drug	$5	$10
Brand name drug listed on WV Preferred Drug List	$15	$30
Unlisted brand-name Drug WV Preferred Drug List	75% coinsurance	75% coinsurance

COMMON SPECIALTY DRUGS

Specialty Drugs have the following characteristics:

- Need frequent dosage adjustments
- Cause more severe side effects than traditional drugs
- Need special storage, handling, and/or administration
- Have a narrow therapeutic range
- Require periodic laboratory or diagnostic testing

All Specialty Drugs require Precertification and are subject to Quantity level limits. HealthSmart reviews for medical necessity, and will coordinate its purchase through an approved source. The copayment is $50 for any medication in this class; 90-day supplies are not available.
Call HealthSmart Specialty Drug Program at 1-888-440-7342.

Common Specialty Drug List			
Drug Name	**Category**	**Drug Name**	**Category**
Acthar® HP	Multiple Sclerosis	Norditropin®	Growth Hormone
Actimmune	Anti-Neoplastic	Nutropin®	Growth Hormone
Adcirca®	Pulmonary Hypertension	Octreotide Acetate	Endocrine disorders
Afinitor	Anti-Neoplastic	Pegasys®[QLL]	Hepatitis C
Ampyra	Multiple Sclerosis	Peg-Intron®[QLL]	Hepatitis C
Aranesp®	Anemia	Procrit®	Anemia
Arixtra®	Anti-Coagulant	Pulmozyme®	Cystic Fibrosis
Avonex®[QLL]	Multiple Sclerosis	Rebif®[QLL]	Multiple Sclerosis
Betaseron®	Multiple Sclerosis	Revatio®	Pulmonary Arterial Hypertension
Boniva®	Osteoporosis	Revlimid®	Anti-Neoplastic, Immunosuppressant
Cerezyme®	Gaucher Disease	Riba pak	Hepatitis
Coopaxone®[QLL]	Multiple Sclerosis	Ribavirin®	Hepatitis C
Eligard	Anti-Neoplastic	Sandostatin LAR	Endocrine disorders
Enbrel®[QLL]	Inflammatory Conditions	Simponi®	Rheumatoid Arthritis
Enoxaparin Sodium	Anti-Coagulant	Sprycel	Anti-Neoplastic
Epogen®	Anemia	Sutent®	Anti-Neoplastic
Forteo®	Osteoporosis	Tarceva®	Anti-Neoplastic
Fragmin®	Anti-Coagulant	Tasigna	Anti-Neoplastic
Genotropin®	Growth Hormone	Temodar®	Anti-Neoplastic
Gilenya®	Multiple Sclerosis	Tev-Tropin®	Growth Hormone
Gleevec®	Anti-Neoplastic	Thalomid®	Anti-Neoplastic
Humatrope®	Growth Hormone	Thyrogen®	Diagnostic
Humara®[QLL]	Inflammatory Conditions	Tobi®[QLL]	Cystic Fibrosis
Incivek	Hepatitis	Tracleer®	Pulmonary Arterial

Common Specialty Drug List			
Drug Name	**Category**	**Drug Name**	**Category**
			Hypertension
Intron A®	Interferons	Tykerb	Anti-Neoplastic
Kineret®	Inflammatory Conditions	Tyvaso®	Pulmonary Arterial Hypertension
Kuvan	Enzyme deficiencies	Victrelis®	Hepatitis
Letairis®	Pulmonary Arterial Hypertension	Votrient	Anti-Neoplastic
Leukine®	Hematopoietic	Xeloda®	Anti-Neoplastic
Lovenox®	Anti-Coagulant	Xenazine®	CNS Disorders
Lupron Depot®	Endometriosis, Anti-Neoplastic, Precocious Puberty	Zoladex®	Anti-Neoplastic
Lupron Depot®	Precocious Puberty	Zolinza	Anti-Neoplastic
Lupron®	Anti-Neoplastic	Zytiga®	Anti-Neoplastic
Methotrexate	Anti-Neoplastic Anti-Arthritis	All Common Specialty Medications require Precertification from HealthSmart. [QLL] This drug is subject to Quantity Level Limits (QLL) This list is not all-inclusive and is subject to change throughout the Plan Year.	
Neulasta®[QLL]	Neutropenia		
Neupogen®	Neutropenia		
Nexavar®	Anti-Neoplastic, Immunosuppressant		

BENEFIT LIMITS

SIX-MONTH WAITING PERIOD FOR PRE-EXISTING CONDITIONS

If you have a pre-existing condition that requires a six-month waiting period, before claims will be paid for your condition, your pharmacist must receive a prior approval before any prescription can be filled. This may require a 24- hour wait before the pharmacist receives the approval or denial. If coverage is denied due to the waiting period, you will be required to pay the full amount for the prescription. This applies only to prescriptions that relate to the pre-existing condition. New prescriptions for other illness or injury will be paid as outlined.

ANNUAL PHARMACY BENEFIT MAXIMUM

AccessWV has an annual benefit limit of $50,000 per member for each Plan year for pharmacy benefits. Annual benefit maximums include only the actual dollars paid by the Plan on behalf of the member (not the member's share of costs.) Once the annual pharmacy limit is reached, AccessWV will no longer pay benefits for prescription drugs for that member for that Plan year.

LIFETIME COMBINED BENEFIT MAXIMUM

AccessWV will pay a maximum of $1,000,000 in total benefits per member during each member's lifetime. This maximum includes benefits paid for medical services and prescription drugs. Once this maximum is reached, the member's coverage will be terminated by the Plan. If the member is the policyholder, coverage will be terminated for the policyholder and dependents. If the dependent reaches the maximum, the dependent will be removed from coverage.

USING A RETAIL NETWORK PHARMACY

Express Scripts has a nationwide network of pharmacies. To get a prescription filled, simply present your medical/ prescription drug ID card at a participating Express Scripts pharmacy. You can purchase both acute and maintenance medications at an Express Scripts network pharmacy. You may refill your prescriptions when 75 percent of your medication is used.

Your ID card contains personalized information that identifies you as an AccessWV member, and ensures that you receive the correct coverage for your prescription drugs. If you use an Express Scripts pharmacy, you do not have to file a claim form. The pharmacist will file the claim for you online, and will let you know your portion of the cost.

If you use a network pharmacy and choose not to have the pharmacist file the claim for you online, you will pay 100 percent of the prescription price at the time of purchase. You may submit the receipt with a completed claim form to Express Scripts for reimbursement. The prescription receipt must be attached to the form. You will usually be reimbursed within 21 days from receipt of your claim form. You will be reimbursed the amount AccessWV would have paid, less your required copay, your deductible (if applicable), and a $3 processing fee. This reimbursement may be less than you paid for the prescription. If you need claim forms, call Express Scripts Member Services at 1-877-256-4680 or visit their website at www.express-scripts.com.

To find the participating pharmacies nearest you, call Express Scripts Member Services at 1-877-256-4680 and use the voice-activated Pharmacy Locator System. If you have Internet access, you can find a pharmacy online at www.express-scripts.com.

USING THE RETAIL MAINTENANCE NETWORK

If you take a drug on a long-term basis, you may be able to purchase a 90-day supply of that drug if it is on the maintenance list (see the “Maintenance Medications” list later in this section). AccessWV offers a Retail Maintenance Network of pharmacies that will fill your 90-day prescription for just two copays. You can buy two months and get one month free. Check with your local pharmacist to verify participation in the Retail Maintenance Network.

USING NON-NETWORK PHARMACIES

If you use a non-participating pharmacy, you will pay 100 percent of the prescription price at the time of purchase, and submit a completed claim form to Express Scripts. The prescription receipt must be attached to the form. You will usually be reimbursed within 21 days from receipt of your claim form. You will be reimbursed the amount AccessWV would have paid at a participating pharmacy, less your required copay, your deductible (if applicable), and a $3 fee. This reimbursement may be less than you paid for the prescription. If you need claim forms, call Express Scripts Member Services at 1-877-256-4680 or visit their website at www.express-scripts.com.

USING THE EXPRESSCRIPTS MAIL SERVICE PHARMACY PROGRAM

Express Scripts provides a convenient mail service pharmacy program for AccessWV members. You may use the mail service pharmacy if you are taking medication to treat an ongoing health condition, such as high blood pressure, asthma, or diabetes.

When you use the mail service pharmacy, you can order up to a 90-day supply of a medication on the maintenance list, as prescribed by your doctor, and pay only two copays. You may refill your prescription when 66 percent of the medication is used up. Express Scripts’ licensed professionals fill every prescription following

strict quality and safety controls. If you have questions about your prescription, registered pharmacists are available around the clock to consult with you.

MAIL SERVICE PHARMACY FOR NEW PRESCRIPTIONS

If you want to use the mail service pharmacy the first time you are prescribed a medication that you will need on an ongoing basis, ask your doctor for two prescriptions: the first for a 14-day supply to be filled at a participating retail pharmacy; the second, for up to a 90-day supply, to be filled through the mail service pharmacy.

There are several ways to submit your mail service prescriptions. Just follow the steps below. Some restrictions apply.

Ordering new prescriptions. Ask your doctor to prescribe your medication for up to a 90-day supply for maintenance medications, plus refills if appropriate. Mail your prescription and required copay along with an order form in the envelope provided. Or ask your doctor to fax your order to 1-800-636-9494. You will need to give your doctor your member ID number located on your ID card.

- **Refilling your medication.** A few simple precautions will help ensure you do not run out of your prescription. Remember to reorder on or after the refill date indicated on the refill slip. Or reorder when you have less than 14 days of medication left.
- **Refills online:** Log on to Express Scripts' website at www.expresss-scripts.com. Have your member ID number, the prescription number (the 9-digit number on your refill slip), and your credit card ready when you log on.
- **Refills by phone:** Call 1-877-256-4680 and use the automated refill system. Have your member ID number, refill slip with the prescription number, and your credit card ready.
- **Refills by mail:** Use the refill and order forms provided with your medication. Mail them with your copay.
- **Delivery of your medication.** Prescription orders receive prompt attention and, after processing, are usually sent to you by U.S. mail or UPS within two weeks. Your enclosed medication will include instructions for refills, if applicable. Your package may also include information about the purpose of the medication, correct dosages, and other important details.
- **Paying for your medication.** You may pay by check, money order, VISA, MasterCard, Discover or American Express.
    - Debit cards are not accepted for payment.

The pharmacist's judgment and dispensing restrictions, such as quantities allowable, govern certain controlled substances and other prescribed drugs. Federal law prohibits the return of any dispensed prescription medicines.

PRIOR AUTHORIZATION FOR CERTAIN DRUGS

Your prescription drug program provides coverage for some drugs only if they are prescribed for certain uses and amounts, so those drugs require prior authorization for coverage. Prior Authorization is handled by the Rational Drug Therapy Program (RDT). If your medication must be authorized, your pharmacist or physician can initiate the review process for you. The prior authorization process is typically resolved over the phone; if done by letter it can take up to two business days. If your medication is not approved for plan coverage, you will have to pay the full cost of the drug.

AccessWV will cover, and your pharmacist can dispense, up to a five-day supply of a medication requiring prior authorization for the applicable copayment. This policy applies when your doctor is either unavailable or

temporarily unable to complete the prior authorization process promptly. Prior authorizations may be approved retroactively for up to 30 days to allow time for the physician to work with and provide documentation to RDT. If the prior authorization is ultimately approved, your pharmacist will be able to dispense the remainder of the approved amount with no further copayment for that month's supply if you have already paid the full copayment. The medications listed below require prior authorization:

Drugs Requiring Prior Authorization	
adalimumab (Humira®)*	itraconazole (Sporanox®)
ambrisentan (Letairis)*	latanoprost (Xalatan®)
amphetamines (Adderall XR®, Vyvanse®)	legend oral contraceptives for dependents (covered for treatment of medical conditions only)
anakinra (Kineret®)*	liragultide (Victoza®)
armodafinil (Nuvigil®)	maraviroc (Selzentry®)
atomoxetine (Strattera®)	modafinil (Provigil®)
becaplermin (Regranex®)	Omega-3-acid ethyl esters (Lovaza®)
bimatoprost (Lumigan®)	oxycodone hydrochloride (Oxycontin®)
bosentan (Tracleer®)*	quetiapine (Seroquel®)
Brand-name medically necessary prescriptions. If the medication your doctor prescribes is a multi-source drug (more than one manufacturer markets the drug) and there is an FDA-approved or "A-B-rated" generic on the market, then AccessWV will pay only for the generic version, unless your physician provides medical justification for coverage of the brand-name drug. If prior authorization is granted, these drugs will be covered as non-preferred brand-name drugs.	raltegravir (Isentress®)
buprenorphine/naloxone (Suboxone®)	rilonacept (Arcalyst®)*
chenodiol (Chenodal™)*	sacrosidase (Sucraid®)
ciclopirox (Penlac®)	sapropterin hydrochloride (Kuvan®)*
clonidine hydrochloride, extended release (Kapvay®)	sildenafil (Revatio®)*
corticotropin (Acthar®)*	stimulants (Concerta®, Focalin XR®, methylphenidate)
dabigatran etexilate (Pradaxa®)	tadalafil (Adcirca®)*
dalfampridine (Ampyra®)	tazarotene (Tazorac®)
dextromethorphan/quinidine (Nuedexta™)	terbinafine (Lamisil®)
diclofenac sodium gel (Solaraze®)	teriparatide (Forteo®)*
eltrombopag (Promacta®)*	tetrabenazine (Xenazine®)*
enfuvirtide (Fuzeon®)*	tolvaptan (Samsca®)
erythroid stimulants (Epogen®, Procrit®, Aranesp®)*	topical testosterone products
etanercept (Enbrel®)*	topiramate (Topamax®)
etravirine (Intelence®)	travoprost (Travatan/Z®)
exenatide (Byetta®)	treprostinil (Tyvaso®)*
fentanyl (Abstral®, Actiq®, Duragesic®, Fentora®, Lazanda®, and Onsolis®)	tretinoin cream (e.g. Retin-A) for individuals 27 years of age or older vacation supplies of medication for foreign travel (allow 7 days for processing)
fingolimod (Gilenya®)	voriconazole (VFEND®)
fluconazole (Diflucan®)	zonisamide (Zonegran®)
	* These drugs must be purchased through the Common Specialty Medications Program.
golimumab (Simponi®)*	
growth hormones*	
guanfacine extended-release (Intuniv®)	
ibandronate (Boniva®)*	
iloprost (Ventavis®)*	

For up-to-date information on drugs requiring prior authorization, please call Express Scripts customer service at: **1-877-256-4680 (Toll Free) or visit the PEIA website at:**
http://www.peia.wv.gov/customers/providers/Pages/prior_authorizations_and_drugs_with_special_limitations.aspx

Specified drugs are subject to change during the plan year if circumstances arise which require adjustment. Changes will be communicated to members in writing. The changes will be included in AccessWV and PEIA's Plan Document, which is filed with the Secretary of State's office.

DRUGS WITH SPECIAL LIMITATIONS – STEP THERAPY

Step Therapy promotes appropriate utilization of first-line drugs and/or therapeutic categories. Step Therapy requires that participants receive one or more first-line drug(s), as defined by program criteria before prescriptions are covered for second-line drugs in defined cases where a step approach to drug therapy is clinically justified.

Step Therapy
Alzheimer's Disease (Aricept®/ODT, Razadyne/ER®, Exelon®, Exelon Patch®, Cognex®)
Analgesics (Ultram/ER®, Ultracet®, Ryzolt®, Rybix™ ODT, ConZip®)
Angiotensin II Receptor Antagonists (Atacand/HCT®, Avalide®, Avapro®, Azor®, Benicar/HCT®, Cozaar®, Diovan/HCT®, Edarbi®, Edarbyclor®, Exforge®, Hyzaar®, Micardis/HCT®, Teveten/HCT®, Tribenzor™, Twynsta®)
Anti-depressants (Cymbalta®, Effexor/XR®, Symbyax®, Wellbutrin XL®, Pristiq®, Aplenzin®, venlafaxine ER, Savella®, Forfivo XL®)
Anti-hypertensives (Covera HS®, Verelan PM®, Norvasc®, Cardene SR®, Sular®, DynaCirc CR®, Tekturna®)
Benign Prostatic Hypertrophy (Avodart®, Proscar®, Jalyn™, Cardura/XL®, Flomax®, Rapaflo®. Hytrin®, UroXatral®)
Beta Blockers (Sectral®, Tenormin®, Kerlone®, Zebeta®, Coreg®, Trandate®, Lopressor®, Toprol XL®, Corgard®, Levatol®, Visken®, Inderal®, Inderal® LA, InnoPran XL®, Blocadren®, Tenoretic®, Ziac®, Lopressor® HCT, Corzide®, Inderide®, Timolide®, Coreg CR®, Bystolic®, Dutoprol™)
Bisphosphonates (Fosamax®, Fosamax Plus D™, Actonel®, Actonel® with Calcium, Boniva®, Atelvia™)
Cholesterol-lowering medications (Advicor®, Altoprev®, Caduet®, Crestor®, Lescol/XL®, Lipitor®, Pravachol®, Vytorin®, Zetia®, Livalo™)
Dipeptidyl peptidase-4 (DPP-4) Inhibitors (Januvia/XR®, Janumet®, Onglyza®, Kombiglyze™ XR, Juvisync®, Tradjenta®, Jentadueto®)
Fenofibrates (Tricor®, Lofibra®, Antara®, Triglide®, Lipofen®, Fenoglide®, Trilipix®, Fibricor®)
Leukotriene Inhibitors (e.g., Accolate®, Singulair®, Zyflo®, Zyflo CR®)
Long-acting Opioids (Avinza™, Embeda™, Exalgo™, Kadian®, MS Contin®, Opana® ER, Oramorph SR™, Nucynta® ER)
Lyrica®, Gralise®, Horizant®, Neurontin®
Migraines (Imitrex®, Sumavel Dosepro™, Alsuma, Amerge®, Zomig®/ZMT, Maxalt®/MLT, Axert®, Frova®, Relpax®, Treximet®)
Mirapex/ER®
Nasal Steroids (Rhinocort Aqua™, Flonase®, Beconase AQ®, Nasacort AQ®, Nasarel®, Nasonex®, Veramyst®,Omnaris®)
Non-Steroidal Anti-inflammatory Drugs (brand-name NSAID e.g., Celebrex®, Flector®, Pennsaid®, Voltaren®)
Overactive Bladder: (Ditropan®, Ditropan XL®, Oxytrol®, Detrol®, Detrol LA®, Sanctura®, Toviaz®, Vesicare®, Enablex®, Sanctura XR®, Gelnique®)
Proton Pump Inhibitors (e.g., Prilosec®, Prevacid®, Nexium®, Aciphex®, Protonix®, Zegerid®, Dexilant®, First® – Lansoprazole and First® –Omeprazole)
Requip/XL®

Step Therapy
Sedative Hypnotics (Ambien®, Ambien CR™, Sonata®, Lunesta™, Rozerem™, Edluar™, Zolpimist™, Silenor®, Intermezzo®)
Selective Serotonin Reuptake Inhibitors (e.g., Celexa®, Lexapro®, Luvox®, Paxil®, Paxil CR®, Prozac®, Prozac Weekly®, Zoloft®, Sarafem®, Pexeva®, Luvox CR®, Viibyrd®),
Strattera®, Intuniv®, Kapvay®
Tetracyclines (Adoxa®, Doryx®, Oracea®, Solodyn®, Oraxyl®, Vibramycin®)
Thiazolidinedione (TZD) (Actos®, Avandia®, Avandamet®, Duetact®, Avandaryl®, Actosplus/Met XR®)
Topical Acne products, kits and cleansers,
Topical Steroids -- various, and
Xopenex®

QUANTITY LIMITS (QLL)

Certain drugs have preset coverage limitations (quantity limits). Quantity limits ensure that the quantity of units supplied in each prescription remains consistent with clinical dosing guidelines and PEIA's benefit design. Quantity limits encourage safe, effective and economic use of drugs and ensure that members receive quality care. If you are taking one of the medications listed below and you need to get more of the medication than the plan allows, ask your pharmacist or doctor to call RDT to discuss your refill options.

1. Antipsychotic Drugs (Abilify® 30 units, FanaptTM 60 units, Geodon® 60 units, Invega® varies, Risperdal® 60 units, Saphris® 60 units, Seroquel® varies, Zyprexa® 30 units, and Zyprexa Zydis® 30 units, Latuda® 30 units)
2. Antiemetics:

Aloxi® is limited to 1 capsule/vial per prescription
Anzemet® is limited to 1 tablet per prescription
Cesamet® is limited to 30 capsules per prescription
Emend® 40 mg is limited to 1 capsule per prescription.
Emend® 80 mg is limited to 2 capsules per prescription.
Emend® 115 mg and 150 mg vial are limited to 1 vial per prescription.
Emend® 125 mg is limited to 1 capsule per prescription.
Emend® Bi-fold Pack is limited to 1 package per prescription.
Emend® Tri-fold Pack is limited to 1 package per prescription.
Kytril® is limited to 2 tablets/1 bottle per prescription
Sancuso® is limited to 1 patch per prescription
Zofran® 24 mg is limited to 1 tablet per prescription
Zofran® 4mg and 8 mg are limited to 12 tablets per prescription
Zofran® ODT 4mg and 8 mg are limited to 12 tablets per prescription
Zofran® Solution is limited to 3 bottles per prescription
Zuplenz® is limited to 12 films per prescription.

3. Abstral®, Actiq®, OnsolisTM, Fentora®. Coverage is limited to 90 units per 30 days
4. Cholesterol Lowering Medications. (Advicor® varies, Caduet® 30 units, Vytorin® 30 units, Altoprev® 30 units, Crestor® 30 units, Lescol® varies, Lipitor® 30 units, lovastatin varies, Mevacor® 30 units, Pravachol® 30 units, pravastatin sodium 30 units, Simcor® 30 units, simvastatin 30 units, Zocor® 30 units and Livalo® 30 units)
5. Diflucan® 150 mg. Coverage is limited to 2 tablets per prescription
6. Enbrel®. Coverage is limited to 4 syringes or 8 vials per prescription Humira®. Coverage is limited to 3 syringes/pens per prescription
7. Long-acting Opioids (Avinza® 60 units, Kadian® 90 units, MS Contin® 120 units, Opana® ER 90 units, Oramorph® 120 units, Oxycontin® 90 units, Exalgo® 30 units, Embeda® 90 units, Nucynta® ER 60 units)

8. Migraine medications. Coverage is limited to quantities listed below:

Generic Name	Brand Name	Quantity Level Limit Per Prescription	Quantity Level Limit for 28-Day Period
Almotriptan tablets 6.25 mg	Axert®	6 tablets	18 tablets
Almotriptan tablets 12.5 mg	Axert®	12 tablets	24 tablets
Dihydroergotamine nasal spray vials, 4 mg/mL vial	Migranal®	1 kits	1 kits = 8 unit dose sprayers
Diclofenac potassium, 50 mg powder packet	Cambia™	9 packets	9 packets
Eletriptan 20 mg, 40 mg	Relpax®	6 tablets	18 tablets
Frovatriptan tablets 2.5 mg	Frova®	9 tablets	27 tablets
Naratriplan tablets 1mg, 2.5mg	Amerge®	9 tablets	18 tablets
Rizatriptan tablets 5 mg, 10 mg	Maxalt®	12 tablets	24 tablets
Rizatriptan tablets 5 mg, 10 mg, orally disintegrating tablets	Maxalt-MLT®	12 tablets	24 tablets
Sumatriptan injection pre-filled auto-injectors, 6 mg/0.5ml	Alsuma®	1 kit (2 syringes)	8 kits (16 syringes)
Sumatriptan injection syringes, 4 mg/0.5 ml and 6 mg/0.5 ml	Imitrex® Statdose System®	1 kit	8 kits = 16 injections
Sumatriptan injection vials, 4 mg/0.5 ml	Generics	2 vials	16 vials
Sumatriptan injection vials, 6 mg/0.5 ml	Imitrex®, generics	2 vials	16 vials
Sumatriptan nasal spray 20 mg	Imitrex®, generics	1 box	3 boxes = 18 unit dose spray devices
Sumatriptan nasal spray 5 mg	Imitrex®, generics	1 box	6 boxes = 36 unit dose spray devices
Sumatriptan needle-free injection vial 6 mg/0.5 mL	Sumavel™ DosePro™	1 box	3 boxes = 18 needle-free devices
Sumatriptan tablets 25 mg, 50 mg, 100 mg	Imitrex®, generics	9 tablets	18 tablets
Sumatriptan (85 mg) and naproxen sodium (500 mg) tablets	TreximetTM	9 tablets	18 tablets
Zolmitriptan nasal spray 5 mg	Zomig®	1 box	3 boxes = 18 unit dose spray devices
Zolmitriptan tablets 2.5 mg and 5 mg, orally disintegrating	Zomig-ZMT®	6 tablets	18 tablets
Zolmitriptan tablets 2.5 mg, 5 mg	Zomig®	6 tablets	18 tablets

9. New drugs approved by the FDA that have not yet been reviewed by Express Scripts' Pharmacy and Therapeutics Committee will have a non-preferred status. PEIA reserves the right to exclude a drug or technology from coverage until it has been proven effective.
10. Nuvigil®. Coverage limit varies.
11. Other Antidepressants (Budeprion SR® 60 units, Budeprion XL® 30 units, Bupropion HCL SR® 60 units, Wellbutrin SR® 60 units and Wellbutrin XL® 30 units, Aplenzin® 30 units)
12. Provigil®. Coverage limit varies.
13. Sedative Hypnotics (Ambien®, Ambien CR™, Doral®, estazolam, flurazepam, Lunesta™, Restoril®, Rozerem™, Sonata®, Edluar™, Zolpimist™, Silenor®, temazepam, triazolam). Coverage is limited to 15 units per 30 days.
14. Selective Serotonin Reuptake Inhibitors (Celexa® 30 units, citalopram HBR 30 units, fluoxetine HCL varies, fluvoxamine maleate varies, Lexapro® 30 units, Luvox CR® varies, paroxetine HCL® varies,

Paxil® varies, Paxil CR® 60 units, Pexeva® varies, Prozac Weekly® 5 units, Sarafem® 30 units, Selfemra™ varies, sertraline HCL® varies, Viibyrd® 30 units, and Zoloft® varies)

15. Serotonin and Norepinephrine Reuptake Inhibitors (Cymbalta® varies, Effexor® varies, Effexor XR® varies, Pristiq® 30 units, Savella® varies, venlafaxine ER® varies)
16. Sprix. Coverage is limited to 5 days of therapy per 90 days.
17. Toradol. Coverage is limited to one course of treatment (5 days) per 90-day period.
18. Tamiflu® and Relenza®. Coverage is limited to one course of treatment within 180 days. Additional quantities require prior authorization from RDT.
19. Vasodilator Antihypertensives (Cardura XL® 30 units, doxazosin mesylate® varies, and terazosin HCL® varies)

DIABETES MANAGEMENT

- **Blood Glucose Monitors:** Covered diabetic insureds can receive a free Bayer Ascensia Breeze2® or Ascensia Contour® blood glucose monitor with a current prescription. Simply ask your pharmacist, and he or she will contact Bayer by fax or mail to request the monitor.
- **Glucose Test Strips:** The Plan covers only Bayer Ascensia® Breeze2 or Ascensia® Contour test strips at the preferred copayment of $15 per 30-day supply. Other brands require a 100 percent copayment.
- **Needles/Syringes and Lancets:** You can obtain a supply of disposable needles/syringes and lancets for the copayments listed below:

Coverage	Needles/Syringes	Lancets
At the retail pharmacy:		
Up to 30 day supply	$10	$5
31 to 60 day supply	$20	$10
61 to 90 day supply	$30	$15
Through the mail service and retail maintenance network pharmacies:		
Up to 30 day supply	$10	$5
31 to 90 day supply	$20	$10

FACE-TO-FACE (F2F) DIABETES PROGRAM

AccessWV members may participate in the WV Public Employees' Insurance Agency's program for diabetics. Under the program, members and their dependents with diabetes or gestational diabetes agree to make regular visits to a participating pharmacist for counseling and health education. The pharmacists works with the member to ensure s/he gets the best diabetes care possible by monitoring the member's a) recommended testing and treatment; b)currently prescribed drugs and knowledge of how to take them; and c) physical activity and nutrition plan.

Members benefit from improved health and quality of life, and also benefit by saving money. Copayments are waived for some prescription drugs, lab tests, and supplies. Face-to-Face is a one-time benefit (except for gestational diabetes). For more information, visit the Face-to-Face Care Management Program website, www.peiaf2f.com, or call PEIA at 1-888-680-7342.

DRUGS OR SERVICES THAT ARE NOT COVERED

The AccessWV Pharmacy Benefit does not cover the following medications or services:

1. Anorexients (any drug used for the purpose of weight loss)
2. Anti-wrinkle agents (e.g., Renova®)
3. Birth control drugs for dependent children
4. Bleaching agents (e.g., Eldopaque®, Eldoquin Forte®, Melanex®, Nuquin®, Solaquin®)
5. Charges for the administration or injection of any drug
6. Contraceptive devices and implants
7. Diagnostic agents
8. Drugs dispensed by a hospital, clinic or physician's office
9. Drugs labeled "Caution-limited by federal law to investigational use" or experimental drugs not approved by the FDA, even though a charge is made to the individual
10. Drugs requiring prior authorization when prescribed for uses not approved by the FDA
11. Drugs requiring a prescription by State law, but not by federal law (State controlled) are not covered
12. Erectile dysfunction medications
13. Fertility drugs
14. Fioricet® with Codeine (butalbital/acetaminophen/caffeine with codeine)
15. Fiorinal® with Codeine (butalbital/aspirin/caffeine with codeine)
16. Hair growth stimulants
17. Homeopathic medications
18. Immunizations, biological sera, blood or blood products, Hyalgan®, Synvisc®, Remicade®, Synagis®, Xolair®, Amevive®, Raptiva®, Vivitrol® (these are covered under the medical Plan)
19. Latisse®
20. Medical or therapeutic foods
21. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a hospital, sanitarium, or extended care facility
22. Medication for which the cost is recoverable under any Workers' Compensation or occupational disease law, through any State or governmental agency, or medication furnished by any other Drug or Medical service for which no charge is made to the member
23. Non-legend drugs (except when included in a compound with a legend drug)
24. Omnipod or other disposable insulin delivery systems.
25. Pentazocine/Acetaminophen (Talacen®)
26. Prescription drug charges not filed within 6 months of the purchase date, if AccessWV is the primary insurer, or within 6 months of the processing date on the Explanation of Benefits (EOB) from the other plan, if AccessWV is secondary
27. Replacement medications for lost or stolen drugs
28. Requests for more than a 90-day supply of maintenance medications, or requests for more than a 30-day supply of short-term medications
29. Stadol® Nasal Spray (butorphanol)
30. Therapeutic devices or appliances, including support garments and other non-medicinal substances, regardless of intended use, except those specifically listed as covered
31. Unit dose medications
32. Vacation supplies, unless leaving the country. If you are leaving the country and want AccessWV to cover a vacation supply, you must submit documentation (copy of an airline ticket, travel agency itinerary, etc.) to substantiate your international travel arrangements. Please allow seven (7) days.

Note: Immunizations, biological sera, blood or blood products, Hyalgan®, Synvisc®, Remicade®, Synagis®, Xolair®, Amevive®, and Raptiva® are not covered under the AccessWV Pharmacy Benefit, but are covered under the medical Plan. For information, call the medical claims administrator, HealthSmart, at 1-866-864-6142.

OTHER IMPORTANT FEATURES OF YOUR PRESCRIPTION DRUG PROGRAM

Your prescription drug program is designed to provide the care and service you expect, whether it is keeping a record of your medication history, providing toll-free access to a registered pharmacist or keeping you in touch with any changes to your program. Express Scripts uses the health and prescription information about you and your dependents to administer your benefits. They also use information and prescription data from claims submitted nationwide for reporting and analysis without identifying individual patients.

When your prescriptions are filled at one of Express Scripts' mail service pharmacies or at a participating retail pharmacy, pharmacists use the health and prescription information on file for you to consider many important clinical factors including drug selection, dosing, interactions, duration of therapy and allergies. Express Scripts' pharmacists may also use information received from your network retail pharmacy.

DRUG UTILIZATION REVIEW

Under the drug utilization review program, prescriptions filled through the mail service pharmacy and participating retail pharmacies are examined by Express Scripts for potential drug interactions based on your personal medication profile. The drug utilization review is especially important if you or your covered dependents take many different medications or see more than one doctor. If there is a question about your prescription, your pharmacist may notify your doctor before dispensing the medication.

EDUCATION & SAFETY

You will receive information about critical topics like drug interactions and possible side effects with every new prescription Express Scripts mails. Your retail pharmacy may also provide you with drug information.
By visiting www.express-scripts.com, you also can access other health-related information. Click on Drug Information or Health Information to browse information relative to specific health interests, get safety tips and answers to the most commonly asked medication questions, or just keep up with timely health issues. To view health information personalized to fit your interests, register with www.express-scripts.com. Any written health information cannot replace the expertise and advice of health care practitioners who have direct contact with a patient. All Express Scripts health information is designed to help you communicate more effectively with your doctor and, as a result, understand more completely your situation and choices.

HEALTH MANAGEMENT

Based on your prescription and health information, Express Scripts may provide information to you on one or more of Express Scripts' Care Management programs, provided as a service to you by AccessWV. Program participants generally receive educational mailings and may receive a follow-up call from an Express Scripts pharmacist or nurse. Express Scripts develops these programs to support your doctor's care, and they may contact your doctor regarding your participation in these programs.

FILING A MEDICAL CLAIM

Medical claims are processed by HealthSmart and should be submitted to:

HealthSmart
P.O. Box 2451
Charleston, WV 25329-2451

This post office box should be used only for AccessWV claims. Please do not submit AccessWV claims to other HealthSmart office boxes. This will only delay their processing. To process a medical claim, HealthSmart requires a complete itemization of charges including:

1. patient's name
2. nature of the illness or injury
3. date(s) of service
4. type of service(s)
5. charge for each service
6. diagnosis and procedure codes
7. identification number of the provider, and
8. medical ID number of the policyholder

If the necessary information is printed on your itemized bill, you do not need to use an AccessWV claim form to submit your charges. Cash register receipts and canceled checks are not acceptable proof of your claim.
If you have other insurance which is primary, you need to submit an Explanation of Benefits (EOB) from the other insurance with each claim, or ask your provider to do so if the claim is being submitted for you. You have six (6) months from the date of service to file a medical claim. If AccessWV is your secondary insurer, you have six (6) months from the date of your primary insurer's Explanation of Benefits processing date to file your claim with AccessWV. If you do not submit claims within this period, they will not be paid and you will be responsible for payment to the provider.

If your claim is for an illness or injury wrongfully or negligently caused by someone else, and you expect to be reimbursed by another party or insurance plan, you must file a claim with AccessWV within six (6) months of the date of service to ensure that the covered services will be paid. Later, if you receive payment for the expenses, you will have to repay the amount you received from AccessWV. See "Subrogation and Reimbursement" for details.

SECTION 4: APPEALS

As a member of AccessWV, you or your representative may make an appeal if you do not agree with a decision made by the Plan. There are several kinds of appeals. These include:

- Medical management (expedited)
- Medical management (standard)
- Administrative (including claims denial)

Medical management appeals are concerned with:

- Precertification or prior approval for out-of-state services
- Continued stays in health care facilities and continuation of other services, such as rehabilitation therapies, where AccessWV has denied a service the member's provider believes is necessary; and
- Pharmacy benefits issues such as prior approval, step therapy and quantity limits

An expedited review may be requested by the member's provider if waiting for a standard decision could seriously jeopardize the member's health or ability to function.

Administrative appeals are concerned with the enforcement of program rules and the details of Plan coverage; for example, the amount that has been paid for a claim, whether or not a service is covered, the application of a waiting period, the denial or termination of coverage, etc.

LEVELS OF APPEAL

The AccessWV Grievance process provides for three formal levels of appeal.

Level 1: Appeal to the Plan Administrator or its third party administrators (TPA's)
Level 2: Appeal to the AccessWV Executive Director
Level 3: Appeal to the AccessWV Grievance Committee

Before a formal appeal is initiated at Level 1, the member, applicant or his/her representative may informally request reconsideration by the Plan Administrator or its TPA.

MEDICAL MANAGEMENT APPEALS (EXPEDITED)

When there are issues of medical necessity, the member's provider may request an expedited appeal, if the provider indicates that waiting for a standard decision could seriously harm the patient's health or ability to function. The member's provider is highly involved in all appeals of medical management decisions.

Informal Review. The member's provider may ask for an immediate reconsideration of the decision. The TPA provider who made the decision will review it and discuss the findings with the member's provider within one business day.

Level 1 (Plan Administrator). The request for an immediate Level 1 appeal is made to PEIA's TPA responsible for the denial of service. (HealthSmart or the Rational Drug Therapy Program). The request may be made by telephone or fax and should be made within 48 hours of the denial. The TPA responsible for the denial then works with the member or member's representative to obtain any additional information and attempts to resolve the appeal at this level within 24-48 hours for an urgent situation and within 5 days for a non-urgent situation, provided that all supporting documents can be obtained. The result is communicated to the member or member's representative by telephone with a written determination within two business days.

Level 2 (AccessWV Office). All expedited appeals not resolved in favor of the member at Level 1 will, if requested by the member or member's provider, receive a Level 2 review which includes an external medical review. This level of appeal may be requested by telephone or fax to the AccessWV office and should be made within 48 hours of the previous determination. A decision will be rendered within 5 working days provided that all necessary supporting documents have been obtained. The result will be communicated to the member or member's representative by telephone with a written determination within two business days.

Level 3 (AccessWV Grievance Committee). This level of appeal may be requested by telephone or fax and should be made within 48 hours of the previous adverse determination. Upon request for Level 3 review, the Grievance Committee will seek an independent external medical opinion on the matter, which will be arranged through the Executive Director. A decision will be rendered within 5 working days provided that all necessary supporting documents have been obtained. The result will be communicated to the member or member's representative by telephone with a written determination within two business days. This request is directed to the Grievance Committee in care of the AccessWV Office.

Contact Information for Medical Management Appeals				
Organization	Kind of Issue	Phone	Fax	Mailing Address
HealthSmart	Utilization Management Including (Precertification, Out-of-State Services, Continuation of Care, etc.)	1-866-864-6142	1-855-841-0120	HealthSmart P.O. Box 3782 Charleston, WV 25329-2451
Rational Drug Therapy Program	Drug Prior Approval (Error or Denial)	1-800-847-3859	1-800-831-7787	Rational Drug Therapy Program WVU School of Pharmacy PO Box 9511, HSCN Morgantown, WV 26506
AccessWV Office	Level 2 Appeal	1-866-445-8491	304-558-8362	AccessWV P.O. Box 50540 Charleston, WV 25305
AccessWV Grievance Committee	Level 3 Appeal	1-866-445-8491	304-558-8362	Grievance Committee AccessWV PO Box 50540 Charleston, WV 25305

MEDICAL MANAGEMENT APPEALS (STANDARD)

The member's provider is highly involved in all appeals of medical management decisions.

Informal Review. If AccessWV does not pre-certify or grant prior approval for a requested service or prescription drug, the member or member's representative may request a reconsideration. The provider who made the decision will contact the member's provider within one day of the request for reconsideration. If the reconsideration is not favorable, a formal Level 1 appeal may be made.

Level 1 (Plan Administrator). Request for an appeal, accompanied by all supporting material, should be submitted in writing to the appropriate TPA within 60 days of the initial determination. Written notice of the Level 1 determination will be sent within 30 days. See above chart for all contact information.

Level 2 (AccessWV Office). If the decision at Level 1 is not in favor the member, the member or the member's representative may request an additional review by writing to AccessWV's Executive Director within 60 days. A medical review will be arranged by the Executive Director. Decision at this level will be rendered within 30 days and will be communicated in writing.

Level 3 (AccessWV Grievance Committee). Request for a Level 3 appeal must be made to the Grievance Committee in writing within 60 days of the unfavorable Level 2 appeal. The Grievance Committee will seek an independent external medical opinion on the matter. The decision at this level will be rendered within 30 working days and will be communicated in writing.

Administrative Appeals (Including Claims Denial) Contact Information for Administrative Appeals		
Issue	Where to Call	Where to Write
Administrative concern (eligibility, billing, etc.)	Plan Administrator HealthSmart 1-866-864-6142	AccessWV c/o HealthSmart PO Box 3782 Charleston, WV 25332-3782
Medical claim denial or error	HealthSmart 1-866-864-6142	HealthSmart P.O. Box 2451 Charleston, WV 25329-2451
Pharmacy claim denial or error	Express Scripts 1-877-256-4680	Express Scripts, Inc. Clinical Appeals-(Client WVA) BL0390 6625 W. 78th Street Bloomington, MN 55439

If you think that an error has been made in processing your claim or reviewing a service, the first step is to call HealthSmart (for medical claims) or Express Scripts (for pharmacy claims) to verify that a mistake has been made. If your issue is related to eligibility for AccessWV or another administrative issue, you should call the Plan Administrator at 1-866-864-6142 to see if the issue can be resolved by telephone.

If your issue cannot be resolved by phone, the next step is to appeal in writing within 60 days of the claim payment or denial or the eligibility decision to the Plan Administrator, HealthSmart, or Express Scripts. Explain what you think the problem is, and why you disagree with the decision. They will respond to you by reprocessing the claim and/or sending you a letter with their response.

If you are not satisfied with the resolution, the second step is to appeal in writing to the Executive Director of AccessWV. You or your representative must request a review in writing within sixty (60) days of getting the decision from PEIA, HealthSmart, or Express Scripts. Facts, issues, comments, letters, Explanation of Benefits (EOBs), and all pertinent information about the case should be included. This second step appeal should be mailed to:

Executive Director: AccessWV
1124 Smith Street
P.O. Box 50540
Charleston, WV 25305-0540

When your request for review arrives, AccessWV will reconsider the entire case. A written decision will be sent to you or your representative within 30 days of receipt of your appeal.

If you are not satisfied with the decision at Level 2, you or your representative may make a Level 3 appeal. This will be a review by the AccessWV Grievance Committee. The request for this review must be made in writing within 60 days of the Level 2 decision and should be addressed to the Grievance Committee.

Grievance Committee: AccessWV
1124 Smith Street
P.O. Box 50540
Charleston, WV 25305-0540

The Grievance Committee will review your case and make a decision within 30 days of receiving your appeal. The decision will be sent to you in writing.

ADDITIONAL RECOURSE

Once a Level 3 appeal has been made and the Grievance Committee has made the determination on behalf of AccessWV, there is no other internal level of appeal available. If the member or applicant is not satisfied with the outcome of the appeal at Level 3, he or she may request a hearing by the West Virginia Offices of Insurance Commissioner (Level 4 appeal). If the member or applicant is not satisfied with the decision made by the WV Offices of the Insurance Commissioner, he or she may further contest the decision through judicial review in Circuit Court (Level 5 appeal). A copy of the full AccessWV Grievance Procedure will be mailed to you upon request.

SECTION 5: OTHER INFORMATION

PROHIBITION AGAINST BALANCE BILLING

Any West Virginia health care provider who treats an AccessWV member must accept assignment of benefits and cannot balance bill the member for any portion of charges over and above the PEIA fee allowance or for any discount amount applied to a provider's charge or payment. This is known as the "prohibition against balance billing." This rule policy against balance billing applies when services are provided in West Virginia. Remember, you are always responsible for deductibles, copays, coinsurance amounts and non-covered services.

NEW TECHNOLOGIES

Upon FDA approval of a new technology, AccessWV determines whether or not to cover the item, service or procedure. These new technologies may or may not be covered. AccessWV often waits until the new technology proves effective before approving coverage. If you have concerns about coverage of a new technology, contact HealthSmart for details.

PATIENT AUDIT PROGRAM

The Patient Audit Program offers rewards when you help detect and correct mistakes on your health care bills. Examine your medical bills for these two types of mistakes:

- Charges for services not received
- Overcharges or overpayments resulting from clerical error or miscalculation

Reported errors must be at least $50 to qualify for the Patient Audit Program and must be submitted within 60 days of the processing date on the Explanation of Benefits (EOB). Complete the Patient Audit Report Form from the Plan Administrator (HealthSmart) and submit it, along with an itemized bill from the provider, the corrected bill (or explanation of disagreement), and a copy of the EOB, to the Plan Administrator (HealthSmart).

HealthSmart or Express Scripts will investigate and recover the overpayment, if justified, from the provider of services. When the overpayment is processed you will be paid 50 percent of the recovered amount, up to $1,000 per Plan year.

HEALTH CARE FRAUD AND ABUSE

By law, AccessWV reports suspected fraud to the WV Offices of the Insurance Commissioner. In addition, AccessWV works with the US Attorney's office in the investigation of potential fraud and/or abuse.
Examples of provider fraud:

Waiving member copays
Balance billing members for services (if a network provider)
Billing for services not provided
Billing for a non-covered service as a covered service [for example, billing a "tummy tuck" (non-covered) as a hernia repair (covered)]
Billing that appears to be a deliberate claim for duplicate payments for the same service
Misrepresenting dates, services or identities of members or providers
Intentional incorrect reporting of diagnoses or procedures to maximize payment (upcoding)
Billing for separate parts of procedures rather than the whole (unbundling)
Accepting or giving kickbacks for member referrals
Prescribing additional and unnecessary treatments (over-utilization)

Examples of member fraud:

Providing false information when applying for AccessWV coverage
Forging prescriptions or selling prescription drugs
"Loaning" or using another member's identification card

If you suspect health care fraud, please call AccessWV's Plan Administrator toll free on **1-888-680-7342** and ask for the Special Investigations Team. You will be asked to provide as much information as possible. The Plan Administrator will investigate your concern and, if appropriate, refer the information to the appropriate legal authorities.

COORDINATION OF BENEFITS

In general, eligibility for other coverage makes one ineligible for AccessWV. However, a member may maintain other coverage for the period of time he or she is satisfying a pre-existing condition waiting period under AccessWV. A member may also maintain AccessWV coverage for the period of time he or she is satisfying a pre-existing condition waiting period under another health insurance policy intended to replace the AccessWV policy.

Under the AccessWV Coordination of Benefits (COB) provision, when a person covered by AccessWV also has coverage under another policy (or policies), certain rules determine which policy is required to pay benefits first. The policy paying first is called the primary plan, and any other applicable policy is called the secondary plan. HealthSmart, on AccessWV's behalf, will request information about other coverage using a questionnaire mailed to the policyholder. If the policyholder fails to respond to the questionnaire, claims will be denied until the information is received. For questions concerning Coordination of Benefits, contact HealthSmart at 1-866-864-6142 (toll-free).

AccessWV is the payer of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under Plan coverage shall be reduced by all amounts paid or payable:
through any other insurance coverage.

- by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance, whether provided on the basis of fault or no-fault.

- by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

HOW COORDINATION OF BENEFITS WORKS

When a claim is made, the primary Plan pays its benefits without regard to any other plans. Then the secondary Plan pays its benefits, adjusting for the benefits paid by the primary Plan. The amount that AccessWV will pay as a secondary Plan depends on what the primary Plan pays.

To calculate the amount AccessWV will pay as a secondary Plan, you subtract the amount your primary Plan pays from the amount AccessWV would have paid if there were no other insurance. If the other Plan paid as much as or more than AccessWV would have paid as the primary Plan, then AccessWV will pay nothing as the secondary Plan. If the other Plan paid less than AccessWV, then AccessWV will pay the difference up to what it would have paid had there been no other insurance.

RECOVERY OF INCORRECT PAYMENTS

If AccessWV or HealthSmart discovers that a claim has been incorrectly paid, or that the charges were excessive or for non-covered services, HealthSmart has the right to recover the payments from any person or any entity. You must cooperate fully to help recover any such payment. AccessWV will deduct overpayments from a provider's check to recover incorrect payments. This provision shall not limit any other remedy provided by law.

This situation may occur if you become retroactively eligible for Medicare, Medicaid, or the WV Children's Health Insurance Program when you are enrolled in AccessWV. Since you lose eligibility for AccessWV once you are granted membership in these programs, your coverage is cancelled retroactively. If AccessWV has paid claims during the period in which you are not entitled to membership, an attempt will be made to recover these payments. You must cooperate fully to help recover these payments. Any premiums you paid during this period will be used to offset any unrecoverable payments.

SUBROGATION AND REIMBURSEMENT

AccessWV may pay medical expenses on a member's behalf in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from, the acts or omissions of a third party, or from the acts or omissions of an AccessWV member where other insurance (such as auto or homeowner's) is available. As a condition of receiving such expenses, AccessWV and its agents have the right to recover the cost of such medical expenses from the responsible party directly (whether an unrelated third party or another covered member) or from the member, if they have already been reimbursed by another. This right is known as subrogation.

AccessWV is legally subrogated to its member as against the legally responsible party, but only to the extent of the medical expenses paid on the member's behalf by AccessWV attributable to such sickness, injury, disease, or disability. AccessWV has the right to seek repayment of expenses from, among others, the party that caused the illness or injury, his or her liability carrier or the AccessWV member's own auto insurance carrier in cases of uninsured or underinsured motorist coverage, or medical pay provisions. Subrogation applies but is not limited to any of the following circumstances:

- Payments made directly, by the person who is liable for an AccessWV member's sickness, injury, disease or disability, or any insurance company which pays on behalf of that person, or any other payments on his or her behalf.
- Any payments, settlements, judgments, or arbitration awards paid by any insurance company under an uninsured or underinsured motorist policy or medical pay provisions on the member's behalf.

- Any payments from any source designed or intended to compensate an AccessWV member for sickness, injury, disease, or disability sustained as the result of the negligence or wrongful action or alleged negligence or wrongful action of another person.

It is the obligation of the AccessWV member to:

- Notify AccessWV in writing of any injury, sickness, disease or disability for which AccessWV has paid medical expenses on behalf of an AccessWV member that may be attributable to the wrongful or negligent acts of another person;
- Notify AccessWV in writing if the member retains services of an attorney, and of any demand made or lawsuit filed on behalf of an AccessWV member, and of any offer, proposed settlement, accepted settlement, judgment, or arbitration award; and provide AccessWV or its agents with information it requests concerning circumstances that may involve subrogation, provide any reasonable assistance requested in assimilating such information, and cooperate with AccessWV or its agents in defining, verifying or protecting its rights of subrogation and reimbursement; and
- Promptly reimburse AccessWV for benefits paid on behalf of an AccessWV member attributable to the sickness, injury, disease, or disability, once he or she has obtained money through settlement, judgment, award, or other payment. Failure to comply with any of these requirements may result in:
- AccessWV withholding payment of further benefits; and
- An obligation by the AccessWV member to pay costs, attorneys' fees and other expenses incurred by AccessWV in obtaining the required information or reimbursement.

By acceptance of benefits paid under the Plan, the AccessWV member agrees that AccessWV's rights of subrogation and reimbursement shall have a priority lien and the right of first recovery against any settlement or judgment obtained by or on behalf of a member. This right shall exist without regard to allocation or designation of the recovery.

These provisions shall not limit any other remedy provided by law. This right of subrogation shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

As with any claim, the claims resulting from an accident or other incident which may involve subrogation should be submitted within AccessWV's timely filing requirement of six (6) months. It is not necessary that any settlement, judgment, award, or other payment from a third party have been reached or received before filing a claim with AccessWV.

AMENDING THE BENEFIT PLAN

The benefits, premiums, cost-sharing and other Plan details will be reviewed at least annually by AccessWV's Board of Directors. Notice of any changes will be conveyed to members at least 30 days prior to their implementation. AccessWV reserves the right to amend all or any portion of this Policy in order to reflect changes required by court decisions, legislation, actions by the Board, actions by the Executive Director or for any other matters as are appropriate. The Policy will be amended within a reasonable time of any such actions.
All changes to benefits and premiums must be filed with and approved by the West Virginia Offices of the Insurance Commissioner.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
If you have questions about this notice, please contact the person listed under "Whom to Contact" at the end of this notice.

SUMMARY

In order to provide you with benefits, AccessWV will receive personal information about your health from you, your physicians, hospitals, and others who provide you with health care services. We are required to keep this information confidential. This notice of our privacy practices is intended to inform you of the ways we may use your information and the occasions on which we may disclose this information to others.
Occasionally, we may use member information when providing treatment. We use member health information to provide benefits, including making claims payments and providing customer service. We disclose member information to health care providers to assist them in providing treatment or to help them receive payment. We may disclose information to other insurance companies as necessary to receive payment, and we may use the information within our organization to evaluate quality and improve health care operations. We may make other uses and disclosures of member information as required by law or as permitted by AccessWV policies.

KINDS OF INFORMATION TO WHICH THIS NOTICE APPLIES

This notice applies to any information in our possession that would allow someone to identify you and learn something about your health. It does not apply to information that contains nothing that could reasonably be used to identify you.

WHO MUST ABIDE BY THIS NOTICE

- AccessWV
- All employees, staff, students, volunteers and other personnel whose work is under the direct control of AccessWV The people and organizations to whom this notice applies (referred to as "we," "our," and "us") have agreed to abide by its terms. We may share your information with each other for purposes of treatment, and as necessary for payment and operations activities as described below.

OUR LEGAL DUTIES

- We are required by law to maintain the privacy of your health information.
- We are required to provide this notice of our privacy practices and legal duties regarding health information to anyone who asks for it.
- We are required to abide by the terms of this notice until we officially adopt a new notice.

HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

We may use your health information, or disclose it to others, for a number of different reasons. This notice describes these reasons. For each reason, we have written a brief explanation. We also provide some examples. These examples do not include all of the specific ways we may use or disclose your information. But any time we use your information, or disclose it to someone else, it will fit one of the reasons listed below. We may also enter into agreements with business partners to perform any or all of the tasks we describe below. The business partner may use or disclose your health information in the same manner as if we were doing it directly, and any agreement we enter with a business partner will require that your privacy be protected the same as if AccessWV were using or disclosing the information directly.

1. **Treatment**. We may use your health information to provide you with medical care and services. This means that our employees, staff, students, volunteers and others whose work is under our direct control may read your health information to learn about your medical condition and use it to help you make decisions about your care. We will also disclose your information to others to provide you with options for medical treatment or services.

For instance, we may use health information to identify members with certain chronic illnesses, and send information to them or to their doctors regarding treatment alternatives.

2. **Payment**. We will use your health information, and disclose it to others, as necessary to make payment for the health care services you receive. For instance, our customer service administrator or claims processing administrator may use your health information to help pay your claims. And we may send information about you and your claim payments to the doctor or hospital that provided you with the health care services. We will also send you information about claims we pay and claims we do not pay (called an "explanation of benefits"). The explanation of benefits will include information about claims we receive for the policyholder and each dependent enrolled together under a single contract or identification number. Under certain circumstances, you may receive this information confidentially: see the "Confidential Communication" section in this notice. We may also disclose some of your health information to companies with whom we contract for payment-related services. For instance, if you owe us money, we may give information about you to a collection company with which we contract to collect bills for us. We will not use or disclose more information for payment purposes than is necessary.

3. **Health Care Operations.** We may use your health information for activities that are necessary to operate this organization. This includes reading your health information to review the performance of our staff. We may also use your information and the information of other members to plan what services we need to provide, expand, or reduce. We may also provide health information to students who are authorized to receive training here. We may disclose your health information as necessary to others with whom we contract to provide administrative services or health care coverage. This includes our administrative services partner (PEIA), and its third-party administrators, lawyers, auditors, accreditation services, and consultants, for instance.

4. **Legal Requirement to Disclose Information.** We will disclose your information when we are required by law to do so. This includes reporting information to government agencies that have the legal responsibility to monitor the state health care system. For instance, we may be required to disclose your health information, and the information of others, if we are audited by state auditors. We will also disclose your health information when we are required to do so by a court order or other judicial or administrative process.

5. **Public Health Activities.** We will disclose your health information when required to do so for public health purposes. This includes reporting certain diseases, births, deaths, and reactions to certain medications. It may also include notifying people who have been exposed to a disease.

6. **To Report Abuse**. We may disclose your health information when the information relates to a victim of abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting, or with your permission.

7. **Law Enforcement.** We may disclose your health information for law enforcement purposes. This includes providing information to help locate a suspect, fugitive, material witness or missing person, or in connection with suspected criminal activity. We must also disclose your health information to a federal agency investigating our compliance with federal privacy regulations.

8. **Specialized Purposes.** We may disclose the health information of members of the armed forces as authorized by military command authorities. We may disclose your health information for a number of other specialized purposes. We will only disclose as much information as is necessary for the purpose. For instance, we may disclose your information to coroners, medical examiners and funeral directors; to organ procurement organizations (for organ, eye, or tissue donation); or for national security, intelligence, and protection of the president. We also may disclose health information about an inmate to a correctional institution or to law enforcement officials, to provide the inmate with health care, to protect the health and safety of the inmate and others, and for the safety, administration, and maintenance of the correctional institution.

9. **To Avert a Serious Threat.** We may disclose your health information if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

10. **Family and Friends.** We may disclose your health information to a member of your family or to someone else who is involved in your medical care or payment for care. This may include telling a family member about the status of a claim, or what benefits you are eligible to receive. In the event of a disaster, we may provide information about you to a disaster relief organization so they can notify your family of your condition and location. We will not disclose your information to family or friends if you object.

11. **Research**. We may disclose your health information in connection with medical research projects. Federal rules govern any disclosure of your health information for research purposes without your approval.

12. **Information to Members.** We may use your health information to provide you with additional information. This may include sending newsletters or other information to your address. This may also include giving you information about treatment options, alternative settings for care, or other health-related options that we cover.

YOUR RIGHTS

1. **Approval.** We may use or disclose your health information for any purpose that is listed in this notice without your written approval. We will not use or disclose your health information for any other reason without your approval. If you authorize us to use or disclose your health information in additional circumstances you have the right to revoke the approval at any time. For information about how to authorize us to use or disclose your health information, or about how to revoke an approval, contact the person listed under "Whom to Contact" at the end of this notice. You may not revoke an approval for us to use and disclose your information to the extent that we have taken action in reliance on the approval. If the approval is to permit disclosure of your information to an insurance company, as a condition of obtaining coverage, other law may allow the insurer to continue to use your information to contest claims or your coverage, even after you have revoked the approval.

2. **Request Restrictions.** You have the right to ask us to restrict how we use or disclose your health information. We will consider your request. But we are not required to agree. If we do agree, we will comply with the request unless the information is needed to provide you with emergency treatment. We cannot agree to restrict disclosures that are required by law.

3. **Confidential Communication.** If you believe that the disclosure of certain information could endanger you, you have the right to ask us to communicate with you at a special address or by a special means. For example, you may ask us to send explanations of benefits that contain your health information to a different address rather than to your home. Or you may ask us to speak to you personally on the telephone rather than sending your health information by mail. We will agree to any reasonable request.

4. **Inspect and Receive a Copy of Health Information.** You have a right to inspect the health information about you that we have in our records, and to receive a copy of it. This right is limited to information about you that is kept in records that are used to make decisions about you. For instance, this includes claim and enrollment records. If you want to review or receive a copy of these records, you must make the request in writing. We may charge a fee for the cost of copying and mailing the records. To ask to inspect your records, or to receive a copy, contact the person listed under "Whom to Contact" at the end of this notice. We will respond to your request within 30 days. We may deny you access to certain information. If we do, we will give you the reason, in writing. We will also explain how you may appeal the decision.

5. **Amend Health Information.** You have the right to ask us to amend health information about you which you believe is not correct, or not complete. You must make this request in writing, and give us the reason you believe the information is not correct or complete. We will respond to your request in writing within 30 days. We may deny your request if we did not create the information, if it is not part of the records we use to make decisions about you, if the information is something you would not be permitted to inspect or copy, or if it is complete and accurate.

6. **Accounting of Disclosures.** You have a right to receive an accounting of certain disclosures of your information to others. This accounting will list the times we have given your health information to others. The list will include

dates of the disclosures, the names of the people or organizations to whom the information was disclosed, a description of the information, and the reason. We will provide the first list of disclosures you request at no charge. We may charge you for any additional lists you request during the following 12 months. You must tell us the time period you want the list to cover. You may not request a time period longer than six years. Disclosures for the following reasons will not be included on the list: disclosures for treatment, payment, or health care operations; disclosures for national security purposes; disclosures to correctional or law enforcement personnel; disclosures that you have authorized; and disclosures made directly to you.

7. **Paper Copy of this Privacy Notice.** You have a right to receive a paper copy of this notice. If you have received this notice electronically, you may receive a paper copy by contacting the person listed under "Whom to Contact" at the end of this notice.

8. **Complaints**. You have a right to complain about our privacy practices, if you think your privacy has been violated. You may file your complaint with the person listed under "Whom to Contact" at the end of this notice. You may also file a complaint directly with the Region III, Office for Civil Rights, U.S. Department of Health and Human Services, 150 South Independence Mall West, Suite 372, Public Ledger Building, Philadelphia, PA 19106-9111. All complaints must be in writing. We will not take any retaliation against you if you file a complaint.

OUR RIGHT TO CHANGE THIS NOTICE

We reserve the right to change our privacy practices, as described in this notice, at any time. We reserve the right to apply these changes to any health information which we already have, as well as to health information we receive in the future. Before we make any change in the privacy practices described in this notice, we will write a new notice that includes the change. The new notice will include an effective date. We will mail the new notice to all policyholders within 60 days of the effective date.

Whom to Contact

Contact the person listed below:

- For more information about this notice, or
- For more information about our privacy policies, or
- If you want to exercise any of your rights, as listed on this notice, or
- If you want to request a copy of our current notice of privacy practices.

Privacy Officer
AccessWV
PO Box 50540
Charleston, WV 25305-0540
1-866-445-8491 or 1-304-558-8264

Copies of this notice are also available at the AccessWV office at 1124 Smith Street, Charleston, WV 25305-0540. This notice is also available on our web site: www.accesswv.org

Where To Call With Questions	
Eligibility Issues	HealthSmart 1-866-864-6142 (toll-free) or on the web at www.healthsmart.com.
Billing Issues	HealthSmart 1-866-864-6142 (toll-free) or on the web at www.healthsmart.com
Health Claims and Benefits	HealthSmart 1-866-864-6142 (toll-free) or on the web at www.healthsmart.com.
Required Pre-Service Review: Precertification and Notification, including Behavioral Health Services, Prior Approval for Out-of-State Care	ActiveHealth 1-866-864-6142 (toll-free)
Medical Case Management	ActiveHealth 1-866-864-6142 (toll-free)
Prescription Drug Benefits and Claims	Express Scripts 1-877-256-4680 (toll-free) or on the web at www.express-scripts.com
Second and Third Level Appeals	AccessWV 1-304-558-8264 or 1-866-445-8491 (toll-free) or on the web at www.accesswv.org
Subrogation and Recovery	Beacon Recovery Group 1-800-874-0500 (toll-free)